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THE COMMUNITY COLLEGE IN MENTAL HEALTH TRAINING, REPORT OF A CONFERENCE TO EXPLORE THE ROLE OF THE COMMUNITY COLLEGE IN TRAINING MENTAL HEALTH WORKERS (ATLANTA, APRIL, 1966).

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A CONFERENCE SPONSORED BY THE SOUTHERN REGIONAL EDUCATION BOARD AND THE NATIONAL INSTITUTE OF MENTAL HEALTH WAS HELD IN APRIL 1966, TO (1) PROVIDE OPPORTUNITY FOR COMMUNITY COLLEGE AND MENTAL HEALTH LEADERS TO CONSIDER SIGNIFICANT ISSUES IN THE TRAINING OF MENTAL HEALTH WORKERS, (2) PROVIDE INFORMATION ABOUT DEVELOPMENTS AND CURRENT PROGRAMS IN THIS FIELD, (3) STIMULATE DISCUSSION OF PROBLEMS INHERENT IN THE PROGRAMS, (4) DEVELOP METHODS OF EVALUATING APPROPRIATENESS OF THE NEW JOBS AND THE ADEQUACY OF THE TRAINING PROGRAMS, AND (5) INDICATE AREAS OF RESEARCH, THIS CONFERENCE REPORT INCLUDES THE TEXT OF 13 PAPERS WHICH WERE PRESENTED AT OR PREPARED AS STUDY GUIDES FOR THE CONFERENCE, AND WHICH WERE CONCERNED WITH THE ROLE OF THE JUNIOR COLLEGE IN PREPARING MENTAL HEALTH WORKERS TO SERVE IN FIELDS RELATED TO NURSING, MENTAL RETARDATION, SOCIAL WORK, VOCATIONAL REHABILITATION, AND GENERAL COMMUNITY SERVICES. (WO)

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THE COMMUNITY COLLEGE IN MENTAL HEALTH TRAINING

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REPORT OF A CONFERENCE / ATLANTA, GEORGIA / APRIL 1966

SOUTHERN REGIONAL EDUCATION BOARD

THE COMMUNITY COLLEGE IN MENTAL HEALTH TRAINING

REPORT OF A CONFERENCE TO EXPLORE THE ROLE OF THE COMMUNITY COLLEGE IN TRAINING MENTAL HEALTH WORKERS / APRIL 1966

SPONSORED BY
THE SOUTHERN REGIONAL EDUCATION BOARD
ATLANTA, GEORGIA
AND
THE NATIONAL INSTITUTE OF MENTAL HEALTH
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FOREWORD

Representatives of community colleges and mental health agencies in the Southern states took part in an exciting and challenging conference concerned with the training of mental health workers by community colleges. The realization of the need to take new steps to solve the manpower shortage, the possibilities seen in the functions of mental health workers, and the formulation of plans to develop programs for the training of mental health workers, were the chief concerns of the conference.

Section I of this report contains summaries of the speeches and discussion.

The second section, on colored paper, contains the full draft of the speeches and the papers prepared for use at the conference.

Thanks are expressed to all the individuals who participated in and contributed to the conference. Particularly, the work of the speakers, the discussion leaders and recorders, members of the Advisory Panel, the authors of the working papers, and the National Institute of Mental Health which funded the project deserve appreciation.

PAUL W. PENNINGROTH, PH.D.
Conference Chairman

May, 1966

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SECTION I

CHAPTER 1

CONFERENCE BACKGROUND

Two years ago the interests of the National Institute of Mental Health (NIMH) and the Southern Regional Education Board (SREB) to increase the manpower supply in mental health agencies were joined around a proposal to explore the role of the community college in mental health training. Professional manpower is insufficient to meet the demands for services in mental health agencies. The need for middle level mental health workers is emerging with the untapped resources of the community college promising an additional resource of manpower.

Community colleges are developing rapidly as a vital part of the American education program. They are growing in number, particularly in the South, and they have demonstrated repeatedly their awareness of the need to offer a variety of training programs. The community college gives emphasis to the educational needs of the community it serves, attempts to provide the educational opportunities needed in the community, offers a variety of training programs which may meet the communities' needs for skilled and informed persons and responds readily to the demonstrable demands for specialized types of training.

The intimate connection of the community college with the community has a counterpart within the mental health movement. Mental health services are moving from the mental hospital to the community. This is best seen in the development of comprehensive community mental health centers. The concentration of patients in out-of-the-way hospitals is no longer the single major characteristic of mental health services. There are out-patient clinics, half-way houses, day or night hospitals, aftercare programs, and the beginnings of prevention services. Current developments permit many patients to continue to reside at or near home.

Another significant type of change is occurring in mental health programs. This is the recognition that individuals possessing less than complete professional training can serve an important role in helping persons who are experiencing emotional distress or mental disabilities. Individuals with differing levels of training can provide important services to people in need of help. Increasingly it is seen that ability and opportunity to help people are not confined to the ranks of the professional person who has received a high level of specialized training. There is another dimension in the role of the helping person which can be developed within or alongside the activities of the professionally trained person. This statement in no way diminishes the importance or the need of the specialized services which can be performed only by persons with professional training.

NIMH made a one-year grant to SREB to study the role of the community college in mental health training. The principal emphasis of the project was a conference to bring together representatives from the community colleges and the mental health agencies. The conference would provide an opportunity to define the need in more specific terms, consider some of the elements of training, and explore possible directions of training of mental health workers. The conference had as its specific objectives:

1. Provide an opportunity for community college and mental health leaders to discuss needs, to share ideas, and to consider significant issues in the process of developing a new class of workers.
2. Become informed of the developments in this field and study programs now in existence.
3. Discuss problems inherent in the development of the special training programs and the necessary job descriptions.
4. Suggest methods of evaluation of the appropriateness of the new jobs and of the adequacy of the training courses established to prepare for these jobs.
5. Indicate areas of research and follow-up activities which would lead to the development of recommendations and their implementation.

The conference was held in Atlanta on April 27-29, 1966. Prior to the conference there were several preparatory activities.

An advisory committee was appointed. It consisted of the following persons:

Dr. Cameron Fincher, Associate Director of the Institute of Higher Education of the University of Georgia

Dr. Lee G. Henderson, Assistant Director of the Division of Community Colleges of the State Department of Education of Florida

Dr. M. J. Otero, Superintendent of the State Mental Hospital at San Antonio, Texas

Dr. I. E. Ready, Director of the Department of Community Colleges of the State Board of Education of North Carolina

Dr. James Reynolds, Professor and Consultant in Junior College Education at the College of Education, University of Texas

Dr. Joe B. Rushing, President of Tarrant County Junior College, Fort Worth, Texas

Mrs. Kathryn Stone, Director Program of Human Resources of the Washington Center for Metropolitan Studies, D. C.

Dr. Nat Winston, Commissioner of Mental Health, Department of Mental Health, Tennessee

Dr. Stephen E. Goldston, Training Specialist of the Training and Manpower Resources Branch of NIMH.

Dr. John E. True, Associate Director, Mental Health Program of the Purdue University Regional Campus at Fort Wayne, Indiana, participated as a guest member.

The advisory panel met several times to outline the basic issues confronting the service agencies and the community colleges, to plan the format and procedures of the conference, to advise on the methods to be used in the selection of conference participants, and to suggest follow-up activities after the conference. The success of the project in large measure results from the valuable advice given by the panel.

It was recognized at an early date that one of the problems facing the conference was the definition of the term "mental health worker" or as spelled

out in more detail "middle level mental health worker." The proposal to utilize mental health workers raised the question; what activities now usually performed by professional people can be carried out by mental health workers with two years of college training. Outlines of the tasks performed by professional people which require less training were prepared by a group of professional persons. Outlines were secured which cut across all professional fields in mental hospitals and institutions for the mentally retarded and also in the fields of psychiatry, clinical psychology, psychiatric social work, psychiatric nursing, vocational rehabilitation, and occupational therapy. Participating in this task were:

Dr. Kenneth S. Nickerson, Department of Psychology, Asheville-Biltmore College, Asheville, North Carolina on "Patient Needs and Trained Helper Functions in the Mental Hospital."

Dr. Gerard J. Bensberg, Jr., Director, Attendant Training Project at SREB on "Job Families in Mental Retardation."

Dr. Jean Gobble, Clinical Director, Central State Hospital, Anchorage, Kentucky, on "Mental Health Workers' Job Description."

Dr. Richard Sanders, Director, Psychological Services, Philadelphia State Hospital, Philadelphia, Pennsylvania on "Graduates of Community Colleges, A Manpower Resource for Mental Health Workers."

Dr. Charles A. Stewart, Dean, the University of Georgia School of Social Work, Athens, Georgia on "Middle-Level Mental Health Manpower and Job Functions Related to Social Work."

Miss Lavonne M. Frey, Director of Nursing, St. Elizabeth's Hospital, Washington, D. C. on "The Mental Health Worker in Nursing Services."

Dr. Charles S. Chandler, Columbia College, Columbia, South Carolina, on "Needs of Vocational Rehabilitation Clients Which Could be Met by Middle-Level Mental Health Workers."

Mrs. Martha Benton, Director, Rehabilitation Therapies, Spring Grove State Hospital, Baltimore, Maryland, on "Mental Health Workers in Rehabilitation Therapies."

Dr. Harold L. McPheeters, Associate Director, Mental Health Training and Research, SREB "The Proposed Activities of a Community Mental Health Worker."

The material prepared by this group was designed to be suggestive of possible types of activities for mental health workers. The papers were not prepared to serve as a rigid model. The papers are presented in Section II.

The advisory panel suggested the participants at the conference should represent a wide range of involvement in education and mental health. Requests were sent to state commissioners of mental health, superintendents of education, and other individuals in education and mental health for suggestions of names of people whose interests and activities would make them appropriate participants in the conference.

Sixty participants, about equally representative of mental health agencies and community colleges gathered for a three day meeting in Atlanta, Georgia, April 27-29, 1966. They represented all the 15 states embraced in the regional

compact. However, some states were more heavily represented in mental health, and some in community colleges although the attempt was made to secure a somewhat equal balance.

The program for the first day was given to presenting basic information and raising the issues before the conference. Dr. Harold L. McPheeters, Associate Director of Mental Health Training and Research at SREB, presented information on the development of mental health services. He emphasized particularly the trends now occurring in mental health services—trends which indicate new and different roles for workers.

Dr. Norman C. Harris, Professor of Technical Education of the Center for the Study of Higher Education at the University of Michigan described the nature of community colleges and the part they are playing in the training of workers.

The proposal to develop a new type of mental health worker was one of the important questions before the conference. A model of the development of a community college program in the training of nurses was presented by Dr. Mildred Schmidt, of the Division of Professional Education of the State Education Department of the University of the State of New York. This model was presented to give the conferees an example of what had been done in one field and some of the difficulties which had been encountered.

The fourth presentation was an analysis of the questions and issues which were before the group. This was presented by Dr. James L. Miller, Jr., Associate Director for Research of SREB.

Discussion groups reacted to the material presented and contributed personal experiences and knowledge. Reports of the discussion groups were fed back to the entire group. Each group spent the last morning in making recommendations which were shared with the entire conference.

Director of the project and the conference was Dr. Paul W. Penningroth, Assistant Director for Mental Health Training and Research at SREB. Dr. James L. Miller, Jr., was assistant project director.

CHAPTER 2

THE CONFERENCE AT WORK

The issues before the conference were many and varied. The information given by the speakers and the exchange of thoughts, facts, and opinions by conferees on these issues made for interesting and challenging dialogue which led in many instances to well-conceived plans for action.

This chapter blends the material presented by the speakers and the discussion of the small groups around the topics of the need for mental health workers, the models to be created, and the problems and obstacles within the framework of trends in mental health and the development of the community college.

NEED

"The need for mental health workers is clearly a tremendous one." This statement by Dr. John True reflected the assumptions underlying the conference and the need to consider tapping an undeveloped manpower resource. Agreement was expressed that new directions in training and roles must be considered if the critical manpower shortage is not to hamper the development of mental health services.

Dr. Harris said the need for semi-professional and technical manpower—"the middle manpower"—is critical in most parts of the nation. "Nearly every state in the union reports a severe shortage of qualified personnel in the medical services fields—nurses, medical and dental technicians, office assistants, X-ray technicians, and other paramedical workers—the demand being in excess of 15,000 newly trained persons each year," Dr. Harris said.

The present supply of mental health professionally trained persons is inadequate to meet the demand and the training resources of the nation cannot meet the need. The development of a "middle-level" mental health worker was one solution offered to meet the dilemma. This theme served as the backdrop for the conference.

Various factors are bringing about this consideration of the development of new types of mental health workers. Dr. McPheeters stated that the expansion of community mental health programs and the extensions into correctional institutions, schools, etc., require the exploration of new sources of manpower. He also said the increasing systematizing and semi-automation of many clinical technologies, the increasing demand of our national economy for more services in mental health to all levels of society, and the new kinds of mental health tasks are reinforcing the demand and desirability for middle-level workers.

MENTAL HEALTH WORKERS

A thorough job analysis in the mental health field is needed to determine what work now being done by professionals can be performed by middle level workers. The papers in Section II suggest many types of activities which do not require the highly specialized skills of the professional person. There is also a need to

analyze the location of jobs, their numbers, the salary structure, status, and incentives involved in the creation of a new job type.

The conference was told by Dr. Goldston that the mental health professionals had not made sufficiently clear what types of middle level workers are needed. "We don't need *a* mental health worker, but many types of workers. We need infant care specialists, child care specialists, therapy workers, counselors of alcoholics, directors of alcohol educational programs, research assistants, interviewers, data gatherers, and nursery school aides, to name a few."

Many of the jobs have not been defined and suitable training has not been provided. It is important to identify the current types of work. It is equally important to consider possible future developments, for the positions of the mental health workers should not be limited to traditional concepts. They should remain open to the emergence of new fields and new practices in mental health services.

Three types of mental health workers were identified by the conference:

1. Innovative roles and functions
2. Generalists ("human services technicians" was suggested as a possible designation)
3. Sub-professional

For the first two types the positions would need to be carved out of the entire professional background and would not have identification with a single professional group. This would make easier innovation but it would present problems of support and relationship. However, the third type as a sub-professional person would provide ready identification with the profession for which he has some training and which provides the basis for his designation.

Although the conference did not attempt to arrive at definitions of mental health workers, there was general agreement about the kinds of persons being discussed. The concept of mental health workers was sufficiently clear to permit consideration of problems related to the development of positions and the training programs to be established.

RECRUITMENT

Granted the creation of positions and the development of training programs in community colleges the question was raised if students would give serious consideration to entering this field. There exists competition from industry as well as the opportunity to continue in a bachelor degree program. Would mental health agencies provide positions with sufficient status, adequate financial and other rewards to be attractive? "Students have not beat down the doors to enter the Purdue training program," Dr. True observed.

A statement by Dr. Harris on the problem of recruitment and selection of students was challenged and discussed. Speaking about community college training in health occupations technologies, Dr. Harris had said:

"Junior colleges which have been offering successful work in the paramedical occupations for years find that, in general, the following attributes are necessary for student success:

1. Ranking in the upper half of the high school graduation class.
2. Demonstrated interest and at least fair ability in the sciences, particularly the life sciences.

3. Performance at or above the 40th percentile on such standardized tests as the SAT battery or the SCAT test, based on national college freshmen norms.
4. Dependability and a sense of responsibility of the highest order.

Issue was taken with Dr. Harris' first point. As one psychiatrist put it, "the whole purpose is to tap the entire manpower pool. The upper half of a class would probably go on to master's, Ph.D., or M. D. levels of training. The lower half of a class is what we need to consider. We need to seek out the married woman, the domestic worker, the unskilled, and the dropouts. When the task is carefully spelled out we don't always need junior college people or the upper intelligence level. We need to look for human beings with a certain sensitivity and ability to work with people."

A hospital superintendent said there was a place in the mental health field for high school graduates without formal academic training but with in-service training in hospitals and community agencies. More complex assignments could be given to a two-year graduate. Bachelor degree persons are needed for group testing, psychological assistants, and social workers.

The best source of personnel in the experience of the Purdue program are women with an equivalent of a recent high school degree. Young men have not been attracted to this field of work.

Although these cautions were mentioned the opinion existed that the creation of suitable jobs for mental health workers with appropriate training programs would induce a number of students to pursue this type of work. A need was stated to inform high school and junior high school students through the school counseling program of the need for mental health workers and the opportunities in this field.

TRENDS IN MENTAL HEALTH

Further reinforcement for the concept of mental health workers was seen in the description of trends now occurring in the mental health field. Dr. McPheeters observed that:

1. The emphasis on treatment of the mentally ill has shifted from long-term, intensive care to various forms of short-form therapies.
2. Treatment facilities, once primarily found in mental hospitals, are also found now in local communities. Increasing concern is expressed for reducing the amount of hospitalization for mental illness.
3. Major emphasis is being placed on rehabilitation of the mentally ill and mentally retarded with vocational rehabilitation and industrial therapy programs being started and expanded to focus on training in job habits, attitudes, skills, counseling and placement. A need for programs in social rehabilitation is also becoming apparent.
4. A more scientific and systematic approach to the prevention of mental illness has taken place in the past few years. Preventive programs are carefully aimed at persons under some kind of stress—perhaps physical, such as for those with chronic illness, perhaps financial, such as for those in poverty, perhaps social such as for minority groups, families of delinquents and migrant families. Work is done with the persons who regularly see these troubled people to help them recognize the stresses and either relieve them or strengthen the person's ability to handle the stress.

5. A renewed interest in what has been called "promotion of positive mental health" is being carried out through schools, churches, industries, well-baby clinics, etc., where there are people in everyday situations but who are properly concerned about raising babies, growing up, courtship and marriage, retirement, etc.

6. Another area of concern of the mental health movement is participation in community development. More and more psychiatrists, psychologists, social workers and psychiatric nurses are being asked to serve on committees, councils, and commissions concerned with poverty programs, urban renewal, aging, juvenile delinquency, adult crimes, recreation, penal code revisions as well as general health and welfare matters. These are not areas of primary mental health responsibility, but areas in which our insights into human behavior should be considered and personnel of the mental health field should be participants in the community's program decisions.

7. In the specific area of mental retardation more emphasis is being placed on community programs and there is greater interest in services for retarded adults and in lifetime adjustment.

8. An increasing interest in program evaluation has brought to light many of the newer trends in mental health. One is the trend to greater concern with the physiology, chemistry and pharmacology of thought, emotion, behavior and mental illness. Another is toward the behavioral science aspects of mental disorder—the roles of culture, society and economics on disorder. In mental retardation the greatest research focus is on the biology and genetics of retardation, but there is also increasing concern for cultural factors.

The federal government has made a major committment to improving services in mental health in recent years through various government sponsored programs, construction funds, and grants.

THE COMMUNITY COLLEGE MOVEMENT

Changes in mental health and related areas of social concern will force changes in training programs. One source for new training programs and for manpower is the rapidly expanding community college. In 1964 there were 117 public two-year colleges in 15 Southern states with an enrollment of 110,000. A year later there were 121 public two-year colleges and enrollment had increased to 150,000.

In his address, Dr. Harris said junior college enrollments have been increasing at the rate of about 20 percent per year for the past 10 years. Over a million and a quarter students will have been enrolled in two-year colleges this academic year.

> Conservative estimates indicate a total enrollment of 2.5 million by 1972. In several states more than half of all freshmen and sophomore students are enrolled in junior colleges, and in California, that figure is nearly 80 percent.
>
> The term "community college" has become popular in the middle west and the east to describe publicly-controlled institutions of the comprehensive type, thus attempting to make a distinction between these institutions and the private or single-purpose "junior college." In the west and south, however, the term "junior college" is preferred to describe all such colleges, and many of these are fully as

comprehensive in concept and practice as any so-called "community college."

Junior colleges range in size from fewer than 500 regular day students to nearly 20,000 in a few urban schools. Some colleges concentrate almost entirely on the needs of regular day, college age youth; others have larger evening, adult enrollments than day enrollments.

Dr. Harris listed some generalizations about junior colleges:

1. The junior college movement is probably the most dynamic educational factor in America today. One measure of dynamism is growth.
2. The private and church related junior colleges will probably continue to put their major emphasis on liberal arts and pre-professional work for students whose eventual goal is a baccalaureate degree.
3. Technical institutes are not growing in numbers, and although existing institutions are experiencing some enrollment increases, there seems to be no ground swell of demand for a rapid growth of the technical institute movement.
4. Two trends can be observed in many states:
   a. Former transfer-oriented junior colleges are tending to add occupational curriculums and become more comprehensive.
   b. Former post-high school technical-vocational schools are tending to add liberal arts and pre-professional courses and become more comprehensive. As a result, single-purpose institutions are decreasing in numbers and comprehensive colleges are increasing.
5. Nearly three fourths of all states now have enabling legislation for community junior colleges. Most such states have supported the enabling legislation with fiscal appropriations for establishing and operating the colleges.

A serious problem, Dr. Harris said, is that of recruiting and employing a quality teaching staff. To maintain a ratio of one teacher to twenty students, 10,000 additional teachers per year will be needed.

Community colleges have set a master's degree level of attainment as being the standard of preparation expected of teachers of academic subjects. Some Ph.D's are recruited and there are also many persons from industry and business teaching in occupational education programs, who may possess only a baccalaureate degree or who, in some cases, may have no formal college work at all.

The most critical faculty shortages this year appear to be in the technical fields related to engineering and industry and in the paramedical and health-technology fields. A conservative estimate of the number of new faculty required for junior college occupational education programs would be 3,000 annually over the next five years.

Speaking about the recruitment and selection of students for health occupations technologies, Dr. Harris told the conference that with the exception of practical nursing, which is a one-year, non-associate degree program, the health technologies require students of fairly high academic ability.

One point Dr. Harris made that was later discussed by conferees was the lack of status enjoyed by the semi-professional and technical worker. Even when colleges have provided excellent facilities and instructional programs, enrollments in these programs are seldom up to expectations, he said.

MODELS

Having agreed that parts of the manpower needs might be met through two-year community college programs, the conference set about to find a model or models. In a speech before the conference, Dr. Miller said:

> . . . should the line of attack be aimed at meeting the specific needs of specific potential employers of two-year graduates as they are individually defined in each community, or should there be some attempt to develop a statewide or nationally acceptable pattern leading toward the emergence of a new occupational identity which would become generally recognized and permit fairly free movement of graduates from community to community and from state to state.
>
> If only local needs are to be met, there is likely to be a great deal of diversity among programs since each presumably would be developed jointly by the community college and a specific agency such as a hospital, community center or school for the retarded, to meet the specific needs of that program at that particular point in time as they are perceived by the program's *current* administrators. In many instances this undoubtedly would have more in it of manpower training (or retraining) than of what we like to think of as education . . . A good deal can be said both pro and con about this concept of occupational preparation.

During a general discussion session, Dr. W. A. Weber said the college with which he is associated in Miami, Fla., is no longer a "community" college, but attracts students from other regions of the country. He said because community colleges are now reaching beyond the local students, national training programs should also be considered.

The need for a specific training program can be determined by a study of local, regional and national occupational information, Dr. Harris said.

> However, local needs ordinarily must be locally determined—preferably by a community survey. Such a survey is a considerable task, requiring (for a community of 100,000 people in a thirty or forty mile radius and a diversified economy) six to twelve months to complete. A full-time director, supported by two or three paid staff and backed up by the interest and participation of scores of local citizens are requisites for such a venture. A budget of from $10,000 to $20,000 is realistic for such a community occupational survey.
>
> If the survey indicates unfilled job needs and predicts sufficient numbers of student enrollees, the next question is can the necessary funds be made available.
>
> In terms of annual unit operating costs, a "transfer-oriented" junior college can have a fine program for a $700 unit cost; while a comprehensive community college with a broad program of semi-professional and technical education is more likely to have a unit annual operating cost approaching $1,000. Records kept on Associate Degree Nursing programs indicate that many of these approach a unit cost of $1,600 or more.

Dr. Harris said he foresees increased and continuing cooperation ahead between community colleges and the medical profession. "A new symbiosis is in the making, and we can give it a good start by our deliberations here."

THE ASSOCIATE OF ARTS DEGREE IN NURSING PROGRAM

A program the conference scrutinized and discussed often as a possible general pattern for mental health training needs was the Associate Degree in Nursing described by Dr. Schmidt.

The proposal that nursing become part of the curricular offerings of community junior colleges was made in 1950. It was based on the recognition that the functions of nursing were changing and becoming more complex.

A project which enlisted the cooperation of seven junior-community colleges and one hospital school had as its purpose the development of a new type of program preparing young men and women for those functions commonly associated with the registered nurse. It was hoped the graduates would qualify for the registered nurse license; meet the community junior college requirements for the associate degree; perform technical or semi-professional functions at the registered nurse level; be prepared to become competent nurses rather than considered to be fully competent.

Some of the conclusions drawn from the evidence collected during the cooperative research study as related by Dr. Schmidt were:

1. Nurses able to carry on the functions commonly associated with the registered nurse can be prepared in the community junior college nursing program.
2. Nursing programs of this type can be set up as integral curriculums in junior and community colleges.
3. Community junior colleges can finance these programs within the financial structure of the institution.

Students were admitted to the first two ADN programs in 1952. The total number of programs now is nearly 180. Many more programs are in the planning stage.

Dr. Schmidt said the development of this new approach to the education of nurses has not been free of problems. Some of those encountered in the development of ADN programs are:

1. The quantity and quality of faculty remains the most serious problem. There is general agreement that teachers of nursing in ADN programs should have at least preparation at the master's level with a major in nursing and with competence to teach in a clinical nursing area. These teachers should have had some exposure to ADN programs, either through formal classwork, seminars, workshops, or planned visits to existing programs and some understanding of the community junior college.
2. The ADN programs exclude the preparation of nurses for managerial or administrative tasks. Employers of ADN graduates have not always placed these workers in the positions for which they have been prepared. There is a need for continuing communication between the college preparing nurses at the technical level and the future employers.
3. The general curriculum design requires a new approach to selection of content and teaching, particularly in the courses of nursing. Approximately one half of the credits are in nursing and one half in the general education areas of natural sciences, social sciences and the humanities. A broad fields approach is utilized for the nursing courses and each semester of the program includes at least one lecture-laboratory course in nursing. Further

identification of appropriate content and necessary learning experiences of the technical level nurse is needed.

4. Many states had either a law or board regulation that required a nursing program to be three years in length. In the majority of states changes have come about and it can now be said that most boards of nursing respect the characteristics of this community junior college program.
5. The nursing program is planned as a whole rather than as a series of isolated courses. This kind of planning requires time and demands that at least the nurse administrator, and hopefully one or two teachers of nursing, be appointed to the faculty and be on the job prior to the admission of students. The nurse administrator should be on the job at least six months prior to the admission of the first class. Colleges have not been accustomed to having faculty so far in advance of the admission of students and some colleges have had no method of financing personnel not involved in teaching. In some instances small grants from foundations helped to cover salaries.
6. The cost of the program was identified as the most discouraging factor administrators had to deal with. The nursing program is costly to operate, not because of equipment, but because of the ratio of students to faculty.

The results of this new venture in education, Dr. Schmidt said, have shown the community junior college to be an appropriate setting for the education of the technical nurse. The ADN programs have attracted students who want to go to college and at the same time study nursing and the more mature women who have raised a family and are now ready to prepare for a second career. A larger number of men students have been attracted to these programs than to the hospital controlled programs.

The development of a technical level nurse has increased the interest and concern about the appropriate utilization of all workers in the occupation of nursing.

CURRICULUM

The conference did not attempt to outline the curriculum needed for the training of mental health workers but it did consider problems which would be encountered in curriculum construction and it did point out some of the characteristics the curriculum should reflect. Mentioned were:

1. Identification of the need in sufficient detail to develop curricula and courses. With a limited number of educational experiences possible in a two-year period of time, inclusion or exclusion of specific courses is dictated largely by the functions to be performed by the worker.
2. Selection and support of an appropriate faculty requires a person or group on the job for a period of six months to a year to promote effective planning and staff utilization. Some educators suggested the professional personnel of mental health agencies located near community colleges be utilized on a part-time basis to plan and to teach.
3. Identification of positions with sufficient clarity to enhance student guidance. Colleges can help students select curricula leading to employment in a mental health setting. General assurance of competitive status and pay must be provided two or more years prior to the point of employment. In many fields, including some of the "glamour" occupations, colleges have been seriously disappointed with actual employment possibilities.

4. Since the consensus of the conference seemed to favor a "generalist" education—generalist being defined as background in the field of mental health which would prepare the student for specialization at a later date—a generalist core should be developed with sub-core or specialty programs.
5. Emphasize supervised work experience integrated into the core content. This would provide meaningful specialty training with the mental health agencies and it would tend to maintain student interest in his chosen field.
6. A general social science type of training was suggested as a pattern by some of the conference members.
7. Work in interview methods and significant social issues should be included.
8. Emphasis was made of the view that junior colleges see themselves in reciprocal relationships with mental health groups in developing meaningful curricula and programs.

PROBLEMS AND OBSTACLES

Numerous problems and obstacles will be faced by community colleges and the mental health field in creating new workers. In a summary report of group discussions, a list of the 14 most outstanding ones was made from the standpoint of both the mental health field and community colleges.

1. Further analysis of the total personnel needs in mental health is needed for clearer understanding of the specific roles of mental health workers.
2. A concerted effort is required to overcome resistance to change in some mental health areas and to sell the need for the mental health worker to present administration and professional staff.
3. Further work is needed in clarifying the role and specific competencies of the mental health worker. Although the consensus seems to favor the generalist, or "people worker" as some have called him nonetheless some specific skills and some degree of specialization merit further consideration. Some degree of on-the-job supervision will be helpful in forestalling under or over-delegation of responsibilities by present staff.
4. The problem of establishing uniform standards of training and licensing or certification of the graduate needs to be considered.
5. There is a need to develop measures of on-the-job effectiveness so that evaluation of the adequacy of the program and the training in the college can be made.
6. Public education for this new role needs to be done possibly with the aid of such groups as the National Association of Mental Health.
7. Recruitment of capable students is an area of utmost concern. Actual employment after two years of education in a college may be an inducement and stipends during the training would be helpful in this respect.
8. Jobs must be available for students upon graduation.
9. Salaries, a problem for the entire field of mental health, will have to be competitive with other jobs based on similar amounts of training.
10. Selection of appropriate students still requires further clarification. Is a relatively high level of academic ability necessary for the types of work envisioned?
11. Problems of coordination are to be expected, particularly with reference to the practicum training. The proximity of the college and the mental health practicum facilities will have to be considered.

12. Lack of adequate faculty and supervisory staff are apt to present continuing difficulties.
13. A name for this mental health worker must be chosen. Suggested were mental health worker, mental health technician, mental health assistant and health services associate. The latter was favored by many as reflecting the associate arts degree and the range of services that might be possible.
14. Financial assistance to most colleges might be needed to help support a director of the program and possibly an instructor for a year or two for planning. Possible sources for such assistance would be the federal government, foundations and state and local mental health and public health groups.

Dr. Harris told conferees that despite the great national need for semi-professional and technical workers, these occupations still do not enjoy status in our society. "This lack of status exacerbates the problem and even where community colleges have provided excellent facilities and instructional programs, enrollments are seldom up to expectations."

CHAPTER 3

THE CONFERENCE RECOMMENDATIONS

A progression from consideration of manpower needs, a description of model programs, and an exploration of the range and extent of problems facing the development of training programs for mental health workers led naturally to suggestions of activities to follow the adjournment of the conference. There was a strong feeling at the end of the conference that continuing activities were necessary—that the conference would have failed if nothing was done to meet the need for additional manpower and if the resources of the community college were not utilized. Some indication of the thoroughness of the discussion and the challenge of the problem is seen in the range of recommendations which were made.

The discussion groups had been asked to make recommendations for the community colleges, for the mental health agencies, and for the Southern Regional Education Board. Although further developments would best come from the joint action of these groups, it was recognized there were specific activities to be carried out by one group alone. Throughout the discussion and implicit in the recommendations was the knowledge that successful training programs are the product of united action by the producers and the consumers. Single action by either is likely to be doomed to failure.

The recommendations from the discussion groups reflected the needs and the problems as they had been discussed in the groups. Most of them were suggestions which could be reacted to at once—the logical next steps. Some were centered on the situation in the states which could be appropriately tackled within the state. Problems of a regional nature were directed to SREB. The recommendations follow:

1. Organize state planning or coordinating committees of representatives from the community colleges and the mental health agencies. This coordinating committee could follow through on some of the comments, backgrounds, and stimulation provided in this conference. The committee could also serve in a planning role.

   It was recognized there was a need for lead time to plan and develop these programs. However, it was said no time should be lost in the formation of these committees. Several states took the initial step at the conference to form a coordinating committee.

2. Make systematic surveys of the possible functions and roles of the mental health worker. The surveys would properly be the activity of the mental health agencies which could survey both the possible and potential employers to determine what they saw in the way of roles, job functions, etc. However, community colleges could help. The agencies to be involved in these surveys should include the official state department of mental health and other departments involved in providing services of a mental health nature, such as education, public health if mental health is not an official part of its program, family and children societies, and community agencies.

A description of the characteristics and the personality of the mental health worker is needed as well as the determination whether training should be of a generic or technical nature

3. Work closely with state commissioners of personnel, directors of civil service boards, and administrators of agencies to set up appropriate job classifications, salary scales, and training standards so arranged that the graduates of the training programs would have suitable jobs available to them. SREB should give its support to the establishment of mental health worker classifications in state systems.
4. Promote the image of the mental health worker. In close liaison with voluntary agencies steps should be taken to correct the distorted and outdated images people have of working in a mental health setting. A specific aspect of this was the suggestion that high school students and their parents be surveyed to determine their attitudes toward these potential mental health worker jobs. The survey might give only very tentative kinds of impressions which might have little predictive value for decisions to be made at a later date.
5. Make known the need for mental health workers to state legislatures, governors, and the general public.
6. Secure immediate relief of the manpower shortage in the mental health field by developing intensive programs, perhaps on an in-service basis, through the continuing education programs available in most community colleges. The proposed mental health workers probably could not be available until 1969 or 1970 and immediate action is desirable. Not only might this increase the immediate manpower supply but more importantly it would give the community colleges an opportunity to develop more practicable and meaningful curriculum.
7. Organize pilot projects between mental health agencies and community colleges, perhaps under the organization of SREB. An investigation of pilot programs in other parts of the country and a closer study of the Purdue Plan were suggested.
8. SREB set up a clearing house with information about mental health worker programs as they are developed in various areas of the nation.
9. Explore and list the sources of funds for student stipends, administrative projects, and pilot studies. Funding sources to be explored include the Office of Economic Opportunity, the Appalachian Program, vocational education, the various institutes of health, the Office of Education, and private foundations.
10. Make a continuing analysis of resources and needs in the region for which SREB could supply the appropriate regional machinery.
11. Recognize attitudes of resistance to change and launch a joint project of the mental health agencies and community colleges cooperating with SREB to study the best ways to deal with this resistance.
12. Schedule another conference six to twelve months later as a follow-up of this meeting.
13. Report as soon as possible to the commissioner or the responsible state mental health authority on the findings of this conference. It would be helpful if SREB made an interim or preliminary report as soon as possible.

A report should also be sent to the official agencies responsible for the institutions for the mentally retarded.

14. The proper mental health authority should arrange departmental or staff meetings to study the conference report and make preliminary plans.
15. Present to professional organizations and specific agencies the findings of the conference to encourage their discussion of the proposed programs.
16. Create a committee with representatives from mental health agencies and community colleges to initiate within the Southern region the steps necessary to provide legislative and financial support.
17. SREB provide consultation service to the state agencies and advisors during the initial period of development.
18. Hold an evaluation conference after the initial period of work has been completed.
19. Each member of the conference return home and survey what is already going on. Acquaintance with those institutions which may already be using some kind of mental health worker would focus on the need and existing resources that are available.

A summer conference this year for Florida community colleges was proposed by the group from that state. Observers could be invited from neighboring states. This state-wide conference could be a responsibility of the community colleges and the state mental health agencies. Careful planning would be needed for the agenda and the level of discussion which would determine the participants in the conference.

At the conclusion of the conference Dr. True said he was not surprised at the nature of the problems which emerged during the three days of discussion. However, he was agreeably surprised at the perceptiveness of the group in recognizing the problems and obstacles.

Dr. Skaggs concluded the conference with a statement of three imperatives he felt should be on the minds of the conferees as they begin their post conference work.

> I think the first imperative is the fair and total recognition of change in the world in which we live. Whether you want to be or not, ladies and gentlemen, you are the generation of destiny. Upon your shoulders must lie the compelling and agonizing task of making the shift, of making the turn toward changes in the future.
>
> My second imperative, I think, is the total involvement of all people. No longer can we walk down the road alone without any planning and developing. Education cannot take this fork and professions cannot take that fork, and the public cannot take some other direction. We must all work together—the total involvement of everyone.
>
> I think perhaps our third imperative is positive implementation. We have no place to go but forward. We cannot go back and I think that we all need to realize that as the needs of society begin to crystalize, somebody is going to do the job, and God forbid that inappropriate people do the job. And unless we in the professions and we in education, the appropriate people do it, somebody else will and we will probably not like the results. We have no place to go but in the positive implementation of these things we have been talking about.

SECTION II

CHAPTER 4

MENTAL HEALTH—THE BROAD PICTURE

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The mentally ill in America were generally kept in jails or poorhouses until the middle of the 19th century. At that time Dorothea Dix began her crusade in the various state legislatures, in Congress and even in Parliament to have asylums built for these people. The states then began building the hospitals for the mentally ill and residential institutions for the educable retarded.

Without effective medications or real knowledge of psychological processes, these hospitals in time grew to huge sizes and became largely custo 'ial warehouses understaffed, overcrowded and dominated by politics. The institutions for retarded also changed to custodial programs for the more severely disabled.

In the early 1900's the work of Dr. Sigmund Freud of Vienna in study of the unconscious and psychoanalysis began to give us knowledge of psychological processes. The process is long and expensive, but it was widely acclaimed in the U. S. and laid the basis for the private practice of the specialty of Psychiatry.

In the late 1930's and early 1940's we made discoveries of electroshock and insulin treatments which indeed offered hope for some of the major mentally ill both in the state hospitals and in private practice.

World War II saw Psychiatry really come into its own as psychiatrists were used in screening and for front line duty in returning psychiatric casualties to early duty. However, the state hospitals remained shamefully backward until several series of journalistic exposees in the late 1940's and early 50's brought about increased public interest.

In 1954 the tranquilizers were introduced and the whole course of American psychiatry was changed. Large-scale use of the psychotropic drugs (both tranquilizers and psychic energizers) and more therapeutic operation of the hospitals has reduced the census of the hospitals by ½% each year since 1955.

In 1963, after earlier study by the Joint Commission on Mental Illness and Health, President Kennedy launched the Community Mental Health Centers Program to give Federal government stimulation and financing to development of local facilities in every community that has specialized medical services of other kinds. The states are now busy building these new centers and planning for staffing and operation of them.

The mentally retarded have also seen increased hope through the action of the National Association for Retarded Children and through the programs of President Kennedy to bring the resources of the Federal government into action. This has concentrated on developing community educational and rehabilitation programs.

For this conference it seems well to give a brief account of the mental health movement, where it has been, the changes now under way and some notion of why we should consider the development of some kind of associate professionals in mental health. At the risk of being tedious for the mental health people, it seems to be most appropriate for our community college leaders who are here.

The mental health field has recently done some serious studying of itself and its practices and has changed some of its traditional practices and patterns. Some of the factors that have led to these changes are:

1. An awareness that with the human being's natural tendency to health, a little support at the moment it is needed may be enough to restore the person to satisfactory functioning. Deep and thoroughgoing analysis may not be necessary.
2. An awareness of the human dignity of each individual patient and a desire to encourage each patient to interact responsibly rather than "doing for" a herd of patients in a custodial sense.
3. The knowledge that hospitalization when not absolutely necessary may be unnecessarily traumatic and dehabilitating.
4. The use of psychotropic drugs which has given an optimistic therapeutic hue to all of our activity.
5. The awareness that other kinds of workers in addition to the traditional mental health professionals could work effectively with disturbed people. This is especially so since the origins of so many disabilities seem to be multiple.
6. The knowledge that our services to people were being seriously biased by economic, social and geographic factors.
7. A growing understanding and acceptance of mental disability by society at large leading to community acceptance of psychiatric services in the general hospitals, early release of patients, acceptance of limited psychiatric disability, etc.
8. The realization that there are not, nor can there ever be, enough psychiatrists, psychologists, social workers, psychiatric nurses, etc. to meet the needs of all of the population if we persist in traditional patterns of service.
9. A broadening concern of mental health field for human behavior within the framework of society rather than a narrow concern for psychosis and neurosis in the framework of the hospital or consulting room.
10. The growing appreciation of the effectiveness of scientifically conceived programs of prevention of emotional maladjustment and promotion of positive mental health.
11. An increasing official support of mental health by the New Frontier, the Great Society, state and local governments.

TREATMENT

The emphasis in *treatment* of mental illness has swung away from long-term, intensive treatment or classic psychoanalysis to various forms of *short-form therapies*. There is a realization that the effect is not as thoroughgoing, but that more sick people can be treated with a reasonably effective level of service through shorter-term treatment.

There is also a considerable increase in *emergency services* with the feeling that if the patient can be given some immediate help at the time of his "psychological hemorrhage," the results may be more effective than if he is required to undertake longer treatment at some future time when his name comes to the top of the waiting list.

Many practitioners, especially psychologists and social workers, are finding *group work* and *family therapy* (that is, working with the entire family as a group) to be an effective way of rendering treatment services to more people. In some kinds of conditions group therapy seems to be actually more effective for the individual patients than individual psychotherapy.

There is also considerable emphasis today on a kind of *re-educational therapy*. This is based on the principles of social learning theory that more effective results can be obtained by simply teaching the patient new and more effective patterns of behavior rather than going through a process of helping him to deeper psychological insights into his behavior.

We have also seen a considerable *shift in the location* in which treatment services are offered from the state mental hospitals *to the communities* in which the patients live. This has increased the number of psychiatric services in community general hospitals, and is the main consideration behind the current emphasis on developing community mental health centers. There is the conviction that the period of hospitalization will be greatly shortened, the dislocation and stigma will be lessened, and the treatment made totally more effective by having it as close to home as other specialized medical services.

There is also growing concern for *partial hospitalization* for mental illness. Since the patient does not need to be in bed 24 hours a day, he may come in from home for day treatment programs or in other cases he may go to his regular job in the daytime and come to the hospital for an evening treatment program.

REHABILITATION

Another gratifying development is a major emphasis on *renabilitation* of the mentally ill and the mentally retarded. This is the process of retraining to live in society. Too often in the past we have simply discharged a patient once the treatment had controlled his hallucinations or delusions without any concern for whether he was prepared to hold a job or to take care of his personal affairs. *Vocational rehabilitation* and *industrial therapy* programs are being started and expanded to focus on training in job habits, job attitudes, job skills, job counselling, and job placement.

There is also a growing awareness of the need for programs in *social rehabilitation* to retrain patients in grooming, budgeting, personal hygiene, home management, assuming responsibility and in helping them develop a personal sense of purposefulness.

CONSULTATION

Also in connection with serving emotionally disturbed people, we now find our psychiatrists, psychologists and social workers helping persons from other walks of life to help them recognize and manage the problems of emotionally disturbed people in their work. Thus our mental health workers are helping public health nurses, teachers, ministers, judges, police, welfare workers, physicians, juvenile court and probation workers to pick up signs of mental disturbance among the people they work with in their professions. More particularly these are other professional persons helped by short training courses and by consultations to

know how they *themselves* can counsel the disturbed person, in most cases without referring the person to a clinic or a psychiatrist.

This has resulted from an awareness that we simply cannot expect to have enough qualified mental health workers to see all the people who need treatment services, and also an awareness that the other professionals may already have a relationship with the disturbed person which can be better used for therapy whereas such a relationship can hardly be established by a psychiatrist in a strange setting such as a clinic or hospital.

PREVENTION

In the past few years we have also seen a more scientific and systematic approach to *prevention*. We no longer think narrowly in terms of prevention of only the major mental disorders such as schizophrenia and manic-depressive psychosis, but rather of prevention of anxiety, depression and all kinds of emotional maladjustment. Preventive programs are carefully aimed at persons under some kind of stress—perhaps physical, such as for those with chronic illness, perhaps financial, such as for those in poverty, perhaps social such as for minority groups, families of delinquents and migrant families. We then work with the persons who regularly see these troubled people to help them recognize the stresses and either relieve the stresses or strengthen the person's ability to handle the stress.

POSITIVE MENTAL HEALTH

In these times we are also seeing a renewed interest in what has been called *promotion of positive mental health*. Now our efforts are more precise and scientific than when we simply talked of a cult of happiness. We now think in terms of programs of education and anticipatory guidance for target groups of people in everyday situations of growth and development to help them be more productive, more comfortable and more responsible in coping with the affairs of everyday living. These efforts are carried out through schools, Sunday schools, churches, industries, well-baby clinics, etc., where there are people in everyday situations but who are properly concerned about raising babies, growing up, courtship and marriage, retirement, etc.

COMMUNITY DEVELOPMENT

Another area which has come to be a concern of the mental health movement is *participation in community development*. More and more psychiatrists, psychologists, social workers and psychiatric nurses are being asked to participate in planning for a better community. Thus we are asked to be on committees, councils and commissions concerned with poverty programs, urban renewal, aging, juvenile delinquency, adult crimes, recreation, penal code revisions as well as general health and welfare matters. These are clearly *not* areas of primary mental health responsibility. Yet they are areas in which our insights into human behavior should be considered and in which we should be participants in the community's program decisions. We should perhaps not merely wait until we are asked to serve in these ways, but should actively volunteer for duty.

MENTAL RETARDATION

In the specific area of mental retardation we also find much more emphasis on *community programs* rather than on institutional programs. At the same time there is greater interest in services for retarded *adults* and in *lifetime adjustment* rather than in services primarily for children.

TRAINING

In training for mental health there is increasing interest in the training of the *traditional mental health professions*, and also in newer rehabilitation areas such as vocational counselors, occupational therapists, chaplains and recreation specialists.

We also see great concern with the development of *middle level professional* workers in mental health. These take many forms such as bachelor degree social workers and vocational counselors rather than the traditional master's degree level; master's degree clinical psychologists rather than the traditional Ph.D. level. It also takes the form of a "mental health worker" at the junior college or community college level of training. The realities of the manpower shortage in the higher levels of training make it inevitable that some kinds of middle level persons will be developed. The precise patterns are not yet clear.

We also see much more work being done in *in-service training* of all levels of present staff workers from psychiatric aides up to psychologists, psychiatrists, social workers and nurses. This training is both to improve their knowledge and skills and to bring them up-to-date with the newer knowledge.

RESEARCH

In *research* there are several current trends. One is the trend to greater concern with the *physiology, chemistry and pharmacology* of thought, emotion, behavior and mental illness.

Another trend is toward the *behavioral science aspects* of mental disorder—the roles of culture, society and economics on disorder. This includes concern for the epidemiology of mental disorder.

In *mental retardation* the greatest research focus is on the *biology and genetics* of retardation, but there is increasing concern for *cultural factors*.

Overall there is an increasing interest in *program evaluation*. How well are we doing with our present programs? Could we use our personnel or facilities better? Where do we need changes? It is from program research of this kind that many of the newer trends have developed.

FEDERAL GOVERNMENT SUPPORT

Another major trend is the major entry of the Federal government into mental health. From 19 years ago when the national government took no interest in mental health, but left it to the states through an increasing concern for *some* community activity and training under the National Mental Health Act (1947) to today there have been great changes. Today we have money for construction and staffing of community mental health centers and retardation centers, training grants for psychiatrists, psychologists, social workers, nurses, psychiatric aides and others, research grants, demonstration project grants, vocational rehabilitation grants, and several other helps through programs such as the Office of Economic Opportunity, Medicare, Economic Development, Appalachia, and the Older Americans Act. Many of these require matching local or state monies, but overall they represent a major commitment of the Federal government to improving services in mental health.

There are several factors leading to our need to consider the development of some kinds of middle-level mental health workers at this time:

1. The shortages of manpower make it impossible for us to carry out our present program commitments without help.

2. The promise of expanded community mental health programs and extensions into corrections, schools, etc., require that we explore new sources of manpower.
3. The increasing systematizing and semi-automation of many clinical technologies make it possible and desirable to use middle-level workers.
4. The awareness that certain newer kinds of mental health tasks especially those of an educational and counseling kind might be carried on by middle-level workers.
5. The increasing demand of our national economy for more services in mental health to all levels of society demands middle-level workers as well as full professionals.
6. The increasing numbers of young people who will seek middle-level training for careers in the health services calls for us to explore their use in mental health.

Overall, it appears that a major change is taking place in the definition of a professional worker. By tradition he is a person who works with his patient or client in a one to one relationship. This is still the direction of training in nearly all of our professional schools. However, the facts of life are that the true professional is becoming the person who develops new knowledge, plans, and organizes services, offers consultation and supervises, trains and evaluates the work of others while the detailed one-to-one work is done by middle-level workers. It appears that this will continue to be the trend of professional development. We in the mental health professions should consider it further and learn to make the best use of it.

As the field of mental health has broadened from a strictly medical-psychiatric concern for the major mentally ill in the mental hospitals, to concern for rehabilitation and restoration for not only these persons but also for the less seriously disabled, and as our concern has spread to include prevention of emotional maladjustment and promotion of positive mental health, the roles of the traditional professions have changed. Others such as educators, counselors, and recreation workers have become as important in their part of the work as the psychiatrists, psychologists, and nurses have traditionally been. What was a rather closed system is now beginning to seek out and welcome helpers of different disciplines and levels of training.

But, while there is a certain willingness to accept middle-level workers and a fair amount of talk about developing them, there is also a general feeling that such workers should be developed in someone else's discipline. Partly because of this attitude and partly because the whole field is in such change that there hasn't been time to make firm role definitions, there is very little actual work being done to develop such a worker.

Would he be something of a practical psychiatric nurse, or more of a psychiatric case work aide? Would he be more like a recreation and craft activity aide, or a general psychological counselor? Would he be the same thing in all areas of the nation or even in different sections of the same city (i.e. in the hospital unit and in the out-patient clinic?). We don't know. We hope our discussions here in the next few days will give us some guidelines.

CHAPTER 5

THE COMMUNITY COLLEGE AND SEMI-PROFESSIONAL MANPOWER

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THE COMMUNITY COLLEGE—A "POLAROID" VIEW

To begin with, let me snap you a picture of the community junior college. The educational landscape will have to be brought into focus; some light will be directed here and there; attention will be given to composing the scene to emphasize its more salient features; and some attention will be given to contrast. The exposure time will be short enough to "freeze the action," and I hope the entire development will not require much more time than it takes to pull a print from a Polaroid camera.

More than a million and a quarter students will have been enrolled in two-year colleges this academic year. Of these, about 1,100,000 are in public community junior colleges and the other 150,000 in independent, or church-related junior colleges and in technical institutes. There are some 480 public community junior colleges now established, and their number has been increasing at the rate of 30 to 40 annually for the past several years.

Independent and church-related junior colleges number about 270 institutions, and some 30-35 two-year technical institutes are now in operation. In general, the privately operated junior colleges tend to emphasize the liberal arts and pre-professional studies and to prepare the majority of their students for upper division work in senior institutions. Technical institutes are ordinarily single purpose institutions offering curriculums of from one to three years' duration which prepare persons for engineering-related jobs in industry.

Publicly controlled community junior colleges typically offer both academic—liberal arts programs for transfer to senior institutions, and a variety of one- and two-year occupational education programs which prepare persons for jobs in the ever growing middle-manpower band of the occupational spectrum.

"COMMUNITY COLLEGES" VERSUS "JUNIOR COLLEGES"—The term "community college" has become popular in the middle west and the east to describe publicly-controlled institutions of the comprehensive type, thus attempting to make a distinction between these institutions and the private or single-purpose "junior college." In the west and south, however, the term "junior college" is preferred to describe all such colleges, and many of these are fully as comprehensive in concept and practice as any so-called "community college." In California, many colleges have dropped the name "junior" and may go by such names as Pasadena City College; Bakersfield College, or Mount San Antonio College. I shall use the terms "community" and "junior" interchangeably, with comprehensiveness of program implied throughout my remarks.

Public junior colleges are, for the most part, commuters' colleges. They offer post-high school educational opportunity at relatively low cost, close to the students' homes, for youth who otherwise might have little opportunity for a college experience. In some states, tuition is free; in others, it is only about $100 per semester; and rarely does it exceed $200 per semester.

Students entering junior colleges are much like their counterparts enrolling as freshmen at four-year colleges. The majority are of typical college age, and most are imbued with an honest desire to learn. Some, of course, are not well prepared for the rigors of college study, and to be sure, more than a few are motivated by other influences than scholastic pursuits. Some come for the first two years of a baccalaureate program; some for an associate degree program which prepares for a semi-professional or technical job; some for short-term pre-employment training; others for post-employment courses to up-grade themselves on the job. As Max Wise has said, "They Come For the Best of Reasons."[1]

PHYSICAL FACTORS—Junior college campuses range all the way from a third floor wing of an old building shared with a high school or junior high school to $30,000,000 college campuses planned and built for the specific purpose of offering two years of post-high school education and a full program of community services to the youth and adults of the district. Architectural styles vary from Greek Revival to Victorian Rococo to California Spanish, to Factory Modern, all depending on geographical location, point in time, and the particular genius and predilection of the architect. Much attention is now being given to the design of new community college campuses and it is to be fervently hoped that the day of the so-called "standard classroom building" is over. Someone, I think it was Winston Churchill, said, "We shape our buildings, and then they shape us." Put another way, learning, like a fluid, takes the shape of its container, so a great deal of thought and planning should go into shaping the container. Consequently, community college planners are beginning to take these thoughts seriously, and are attempting to clarify educational objectives and learning concepts *first*, so that concrete, and brick, and laminates, and steel can be brought together to enhance the teaching-learning function rather than just house it.

SIZE AND DIVERSITY—Community colleges are small in some areas, large in others. Over 100 colleges have fewer than 500 regular day students, and in many parts of the country a student body of 1,000 would be considered large. In contrast, a few urban junior colleges now have enrollments approaching 20,000 students, and a score or more of California's junior colleges are in the 5,000 to 10,000 range. Some colleges concentrate almost entirely on the needs of regular-day, college-age youth; others have larger evening, adult enrollments than day enrollments.

Despite the great diversity and variety in types of junior colleges, some generalizations can be made. Here are a few to fill out the picture:

1. The junior college movement is probably the most dynamic educational factor in America today. One measure of dynamism is growth, and junior college enrollments have been increasing at the rate of about 20 percent per year for the past ten years. Conservative estimates indicate a total enrollment of 2.5 million (double that of this year) by 1972. In several

[1] Wise, Max. *They Come For The Best of Reasons*, American Council on Education, Washington, D. C., 1958.

states more than half of all freshman and sophomore students are enrolled in junior colleges, and in California, that figure is nearly 80%.

2. The private and church-related junior colleges will probably continue to put their major emphasis on liberal arts and pre-professional work for students whose eventual goal is a baccalaureate degree.
3. Technical institutes are not growing in numbers, and although existing institutions are experiencing some enrollment increases, there seems to be no ground swell of demand for a rapid growth of the technical institute movement. There is in some states, however, a flurry of activity to establish post-high school area vocational-technical schools with financial assistance from federal funds.
4. Two trends can be observed in many states:
   a. Former transfer-oriented junior colleges are tending to add occupational curriculums, become more comprehensive.
   b. Former post-high school technical-vocational schools are tending to add liberal arts and pre-professional courses, becoming more comprehensive.

   As a result, single-purpose institutions are decreasing in numbers and comprehensive colleges are increasing in numbers.
5. Nearly three-fourths of all the states now have enabling legislation for community junior colleges. Most such states have supported the legislation with fiscal appropriations for establishing and operating the colleges.

   A fiscal arrangement common in many states is:
   a. For operation
      ⅓ from student tuition
      ⅓ from a local district tax
      ⅓ from state appropriations
   b. For capital outlay
      ½ from a local district tax
      ½ from state appropriations

AGREED-UPON FUNCTIONS—The chief administrators and governing boards of public community junior colleges have reached some measure of agreement on five major functions for their institutions. These are:

1. To provide liberal arts and pre-professional curriculums and courses of a college-parallel type which will enable students to complete lower-division "transfer" requirements at the local institution and then enroll in a senior college.
2. To provide a variety of occupational education curriculums and courses designed to prepare those who complete them for jobs in the semi-professional, technical, and skilled occupations.
3. To provide a program of general education, including basic or developmental courses, for those not ready for or not interested in "transfer," or specialized occupational programs.
4. To provide a quality program of guidance, counseling, and placement services for all students—youth and adults.
5. To provide a well-rounded program of community services, including such activities and events as fine arts festivals; community needs conferences; lecture series; seminars for business, industry, and agriculture; and coordination of educational services offered by other agencies or institutions.

Let me peel this small snapshot from the emulsion then, and leave it with you. I realize that details are probably not clear as yet, but in what follows, I hope the picture may be enlarged, and that background detail will be filled in.

WHY COMMUNITY COLLEGES?

Perhaps it would be well to ask at this point—"Why does America need community colleges? After all, we have almost universal high school attendance through age sixteen, and a well developed system of liberal arts colleges, state colleges, and universities throughout the nation. Why two-year colleges?" Let me deal with this question under three headings:

1. *The technological revolution*, in which automation has combined with mechanization to require new kinds of skills and knowledge in factories, in offices, and on farms.
2. *The population explosion*, whose time-delay fuse has now run out, and whose full shock wave is being felt in this decade, as twenty-six million youth will reach working age and look for jobs.
3. *The kinds and levels of education and training* which can best prepare millions of youth for today's and tomorrow's jobs.

A brief analysis of the first two factors will serve as a suitable backdrop against which the third factor can be viewed in some detail. First, let us agree that education does not create jobs, and that certainly it is not the sole answer to full employment. It is, however, such an important factor that major emphasis will be given to it this morning. Also, let it be understood that *job-training per se* is not the primary concern of community colleges. Community college occupational education programs go far beyond mere job training.

THE TECHNOLOGICAL REVOLUTION—It is difficult indeed for the imagination to grasp the real import of the revolution which an exploding technology has brought upon us in the short span of three decades. In the *manufacturing* industries we have moved in thirty years from a work force structure in which the major emphasis was on skilled, semi-skilled, and unskilled workers to one which now stresses the importance of semi-professional, technical, and professional workers. Repetitive jobs are now the domain of the machine, not man, and although the demand for *highly skilled* workers remains firm, industry's need for *unskilled* workers is decreasing year by year at a rate which predicts 1970 as the vanishing point in time for the "un-skilled job."

As a rather striking example of changing job demands within industry and business, let me cite the case of the du Pont Company of Wilmington, Delaware. In a recent issue of *Better Living*, the du Pont employee magazine, the following trends were emphasized:

1. A 95% increase in white collar workers in the past 15 years.
2. A 100% increase in professional and technical workers.
3. A 240% increase in technicians and specialists associated with automation, computer programming, data processing, and business office systems.

Contrast these phenomenal *increases* with the following:

4. Only a four percent increase in the past decade in highly skilled workers, and no increase at all in semi-skilled workers.
5. A 40% decrease in un-skilled workers.

"Clearly," the du Pont magazine warns its readers, "the future belongs to the skilled and the educated."

The problem of technological unemployment is likely to be even more pronounced in agriculture than it is in industry. Fifty years ago one farmer, by his and his family's labor, produced enough food for his family and six other persons. By 1965, one farmer, in an era of mechanized and chemically fertilized agriculture, was producing enough for twenty-seven others. Seven percent of the population of the United States is producing all the food and fiber needed by the entire nation plus enough to meet all our export markets and pile up troublesome surpluses besides. "Farm labor" is a disappearing segment of the labor force—the farm is no longer a haven for the unskilled and uneducated laborer.

The business office too, reflects the technological revolution. Never a source of jobs for the unskilled, the business offices of the nation were, however, until a decade or so ago, a ready source of jobs for semi-skilled and skilled workers. Millions of persons, comprising this year nearly 25% of the total labor force, are employed in clerical and kindred jobs, and although there is no significant decline in *absolute numbers* of clerical jobs, the demands of office jobs are changing rapidly. The routine jobs—posting, billing, checking, filing, telephone operating, packaging, inventorying—are being taken over by machines, swept up in the cybernetic revolution of our time. The total number of business jobs is holding up well, even increasing slowly, but the old, simple jobs are going, and the new, complex jobs demand persons with advanced levels of education and training.

So, in industry, on the farm, in the business office; wherever people work, wherever people look for work; the message is clear and unmistakable—education is becoming almost the only bridge to employment opportunity.

THE POPULATION EXPLOSION—The "baby crop" of the late 1940's is now in the full bloom of late adolescence and early adulthood. The twenty-six million youth who will look for jobs during this decade represent an increase of 40 percent over the number of youth absorbed by the labor force in the decade of the 1950's.[1] Nationally, perhaps 40 percent of the high school graduates of the '60's will enroll for some kind of post-high school study, but this figure will be attainable only if we make unprecedented efforts to build new colleges and technical schools and expand the enrollment capacity of existing colleges between now and 1970. Furthermore, we must not be satisfied with a 40 percent figure. Evidence from studies of job demands and employer requirements lends support to the oft-heard statement that, and I quote a personnel manager of a large Michigan firm, "new high school graduates just do not have the knowledge and skills required for jobs with our company." The relationship of education to unemployment (and obviously, to employment) was clearly shown in a 1962 study by the U. S. Department of Labor, which showed a 10% unemployment rate for persons who had not completed the 8th grade; a 7% rate for high school leavers; and a 4% rate for those with a high school diploma. In contrast, the unemployment rate for persons with some college (not necessarily the baccalaureate degree) was only 2%. These percentages probably do not hold today, since unemployment in this boom year is far below 1962 levels, but the same *relative* conditions would be true, I am sure.

Partially hidden from view in the complex panorama of employment and unemployment is the anomaly of *job* shortages at the skilled and semi-skilled levels; and *manpower* shortages at the technical, semi-professional, and professional levels. For every "common labor" job there are perhaps two applicants,

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1 U. S. Department of Labor. *Manpower: Challenge of the 1960's*. Government Printing Office, Washington, D. C. 1961.

even today; and for every well-trained semi-professional technician, there are perhaps two jobs! Manpower problems then, are to a considerable extent, merely educational problems. A major task facing the nation (and the Southern Regions) today is the expansion and re-structuring of our educational system to provide the kinds of education and training which millions of youth need in order to cope with present and future economic and social developments.

The national need for semi-professional and technical manpower has been well emphasized by the press over the past several years, and the need for these "middle manpower" workers is critical in most parts of the nation. With regard only to those technicians who work in engineering and industry, the National Science Foundation in a 1964 study concluded that nationally, approximately 68,000 new semi-professional technicians must be educated each year for the next decade to close the so-called "technician gap" by 1975. If this is a true picture of demand, what about the supply?

The supply picture is rather grim. Exact figures on the current output of trained technicians are difficult to come by, but the best estimates I can make from all available sources of information seem to suggest an annual total now of only about 30,000. Included in the list of sources are technical institutes, community colleges, armed services training, industry training schools, and on-the-job training programs. The present gap between supply and demand is then about 38,000 per year.

If we add all the semi-professional job openings in business, agriculture, health, and public service fields to those in industry, the technician gap rises to well over 100,000 per year. Business offices alone need 20 to 25 thousand new semi-professional workers each year in data programming, statistical analysis, and specialized secretarial and accounting work.

Nearly every state in the union reports a severe shortage of qualified personnel in the medical services fields [2]—nurses, medical and dental technicians and office assistants, X-ray technicians, and other paramedical workers—the demand here being in excess of fifteen thousand newly trained persons each year. The advent of Medicare this summer is apt to create intolerable strains in an already critical manpower situation.

COMMUNITY COLLEGE PROGRAMS—The kinds of training programs now in operation in community colleges from Boston to San Diego and from Seattle to Miami, are illustrated in the following sequence of slides. The job titles are grouped in "clusters" or "families" to show relationships to training programs.

This then is the spectrum of middle-level occupations. [3] These jobs, in the aggregate, may account for more than one-third of the labor force by 1975. Four-year colleges and universities do not seem to be interested in educational programs for these jobs. High schools, in my opinion, cannot successfully offer programs of semi-professional and technical education for two reasons: 1) there is not time for both basic education and the depth of specialized education required in the four (or three) years of high school; and 2) most high school

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[2] See "Crisis Now Near In Medical Care?" *U. S. News and World Report*, March 7, 1966, pp. 38-41.

[3] See also, Harris, Norman C. *Technical Education In The Junior College*; The American Association of Junior Colleges, Washington, D. C., 1964, and the following:
Light, Israel. "Training For Health Occupations," *Junior College Journal*, March, 1963.
McCallum, William J. "Jobs For Medical Laboratory Assistants," *Occupational Outlook Quarterly*, Vol. 10, No. 1, February, 1966; U. S. Dept. of Labor, Washington, D. C.
"Training For Health Service Occupations;" Special Supplement to *Washington Report*, Chamber of Commerce of the United States, Washington, D. C., February 26, 1965.
"Manpower For The Health Field," *Hospitals Journal*, Vol. 37, No. 18, September 16, 1963.

youths are too immature to profit from specialized occupational education.

Technical institutes certainly offer some excellent educational programs, but there are so few of these institutions that their total output is a mere ripple on the surface of need.

Consequently, it is only the community junior college that has the potential *and the commitment* to the kind of education and training which can close the middle manpower gap. But all is not peaches and cream here either. There are serious problems within the junior college movement which should be brought into focus, and I will try to sharpen them up now.

THE EDUCATIONAL ENVIRONMENT IN COMMUNITY COLLEGES

Dr. Leland Medsker [4] (in the late 1950's) and Medsker and Dorothy Knoell [5] (more recently) have made detailed studies of community college students and their abilities and aspirations. Some of their findings are listed here:

1. Typically, junior college students come from families in the middle and upper-lower socio-economic classes.
2. Although there are some very bright students in junior colleges, the distribution of academic aptitude is somewhat skewed toward the low end, when compared with similar distribution curves of students in four-year liberal arts colleges and universities. The mean I. Q. of freshman students in a typical "open-door" community college is of the order of 107. Stated another way, the mean percentile on the SCAT (or SAT) test for freshmen in community colleges is at about the 44th percentile, based on national norms for college freshmen. (As compared with the 50th percentile for all college students).
3. Despite these socio-economic and academic standings, two-thirds of entering freshmen aspire to a career in the professions, and insist on being allowed to take a college-parallel curriculum. They are encouraged and abetted in this drive by their parents. their peers, and by high school counselors and faculty. (Only about 15 percent of the labor force of the country is in the recognized professions, but two-thirds of community college freshmen enroll in the academic program.)
4. Only one in four of entering community college freshmen matriculates as a junior at a four-year college two years later, and only about one in three ever does.
5. Despite the great national need for semi-professional and technical workers, these occupations still do not enjoy "status" in our society. This lack of status exacerbates the problem and even where community colleges have provided excellent facilities and instructional programs, enrollments are seldom up to expectations.

Consequently, one of the critical problems facing the community college is to bring about a better match between the aspirations and the abilities of students in order to make the college experience meaningful for thousands who now are "transfer" drop-outs. Only by greatly improved guidance and placement services can this situation be significantly improved. A complete guidance program consists of all the facets shown on the following flow chart on page 34.

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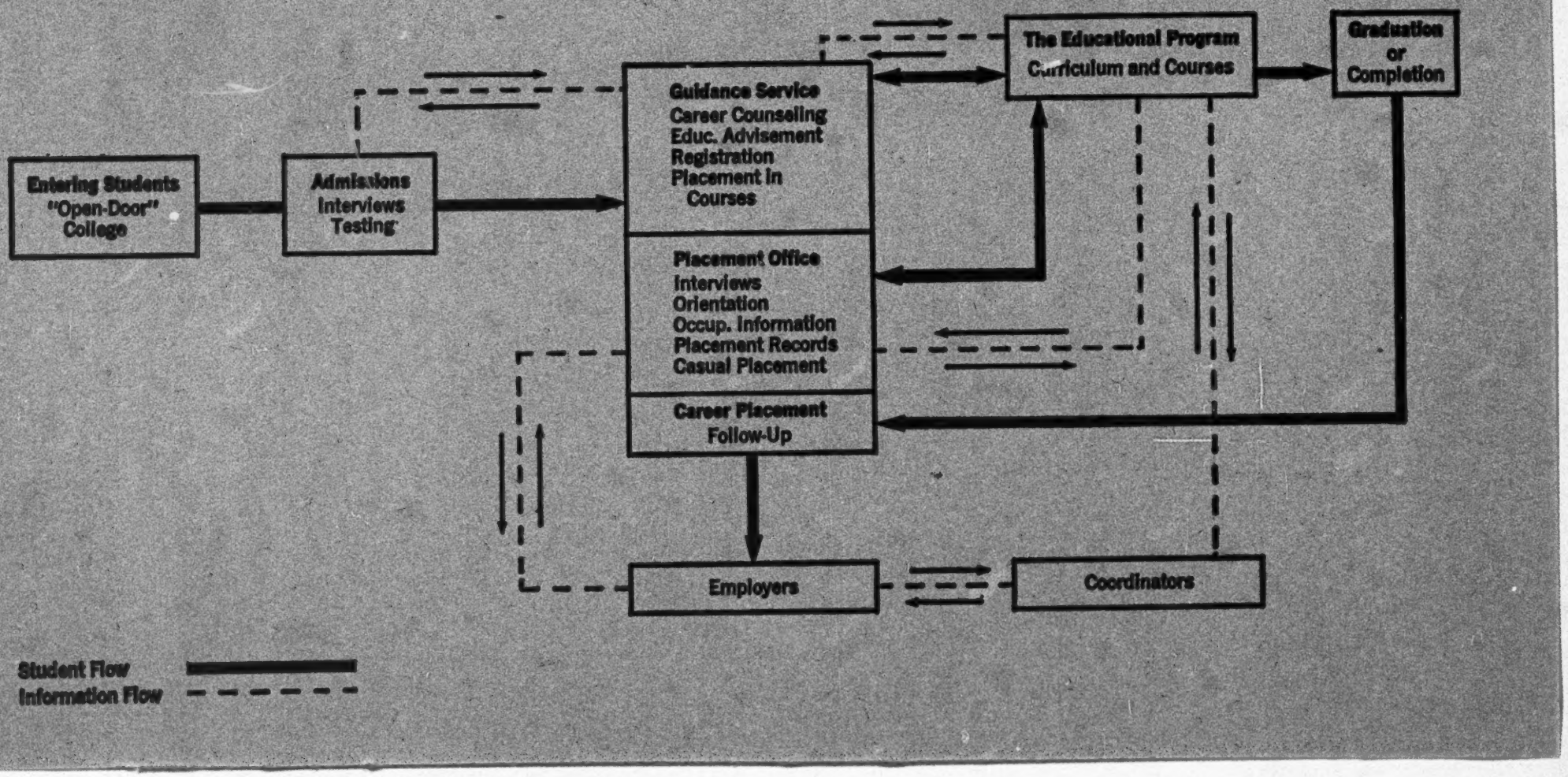
[4] Medsker, Leland. *The Junior College: Progress and Prospect*, McGraw-Hill Book Company, New York, 1960

[5] Medsker and Knoell, Dorothy. *Factors Affecting Performance of Transfer Students From Two- to Four-Year Colleges*, Cooperative Research Project No. 1133, University of California, Berkeley, 1964.

Flow-Chart
Guidance — Placement — Follow-Up
Community College Programs



FACULTY—Another serious problem is that of recruiting and employing a quality teaching staff. We can expect that community college enrollments will increase by about 200,000 students per year over the next five years. This means 10,000 additional teachers per year if we are to maintain a 20:1 ratio. Where will they come from?

Community colleges have set a master's degree level of attainment as being the standard of preparation expected of teachers of academic subjects. Some Ph.D's are recruited, of course; and there are also many teachers, especially those recruited from industry and business for occupational education programs, who may possess only a baccalaureate degree, or who, in some cases, may have had no formal college work at all. In general, well qualified teachers for occupational programs are in shorter supply than are those for traditional college courses. Salary schedules which discriminate against persons without degrees and college credits are an obstacle difficult to overcome. The most critical faculty shortages this year appear to be in the technical fields related to engineering and industry, and in the paramedical and health-technology fields. A conservative estimate of the number of new faculty required for junior college occupational education programs would be 3,000 annually over the next five years.

ADMINISTRATION—One very troublesome factor which militates against increased status for occupational education is the "tone" set by governing boards and administrators of some community colleges. When does a community college become *truly comprehensive*? When a technical building is built? No. When a dean of technical education is employed? No. When the Board of Trustees approves some advisory committees? No. Important as all these steps are, they will not of themselves produce the desired result. Occupational education will acquire status largely to the extent that the president himself becomes *personally identified* with the occupational education program. The community college president himself can determine by his actions and his words whether technical education grows toward new status in the college and in the community, or whether it merely exists and stagnates in the face of need, stunted in the shadow of the transfer program.

College teachers are astute persons. So are college students, and so too are most citizens. It doesn't take much sagacity on their part to ascertain which facets of the community college program the administration regards as being important, and these same facets will be of first importance to them.

Let me take a negative stance here, and paraphrasing that old mystery melodrama, "Seven Keys To Baldpate," give you "Seven Keys to Certain Doom" for community college occupational education.

1. House the occupational program somewhere off on the other side of the campus, well away from the "respectable" liberal arts and academic programs. These ancillary activities shouldn't get in the way of the "central business" of the college.
2. As the chief administrator, always genuflect when referring to the transfer program, and off-handedly refer to the technical-vocational program as Bill's (the director of technical education) program.
3. Give the graduates of the transfer program an associate degree, but dole out a certificate of some kind to the technical graduates. Those Carnegie units must not be compromised.
4. Refuse to provide any specialized courses in physics, math, English, or social studies for the technical-vocational students;—just put them in the courses designed for transfer students. After all, English is English!

5. Don't let anybody from *operating levels* of local industry and business advise you, but be sure to make any changes a company president suggests when he corners you at Rotary Club.
6. Be sure to put the total instructional program under an *academic* dean, so that you as the chief administrator will not have to deal directly with the occupational education faculty. And devise a salary schedule based on degrees and college credits rather than on professional, business, or industrial experience.
7. And finally, the 7th key: Sedulously avoid major budget allocations for technical laboratories or costly equipment—after all, there isn't enough money for everything and transfer students are more important than employment-bound students; so first things first.

Well, obviously, I hope these keys get lost! They will not unlock very many doors of educational opportunity. The community junior college can be a great force in America, dedicated to opening doors for average young people. But some community college boards and presidents need a new set of keys.

CURRICULUM PATTERNS

It occurred to me that it might be instructive to some persons in the audience to devote the closing section of my paper to a brief discussion of how community college occupational education curriculums are developed, planned, and offered.

ASSESSING NEED—The need for a specific training program can be determined by a study of local, regional, and national occupational information. Data on national occupational trends and manpower needs are readily available from such sources as the U. S. Department of Labor, the President's Manpower Commission, the Engineers' Joint Council, the U. S. Chamber of Commerce, the National Science Foundation, the National Institutes of Health, and similar bureaus, agencies, and associations.

Regional needs can be ascertained in like manner from state agencies, or from data available from interstate compacts. Census data by region, are also useful for planning purposes. Regional associations of manufacturers and chain banks operating across state lines also make frequent economic and manpower studies useful to educators.

Local needs ordinarily must be locally determined, and the best way to do this is by means of a community survey. Such a survey is a considerable task, requiring (for a community of 100,000 people and a diversified economy) six to twelve months to complete. A full-time director, supported by two or three paid staff, and backed up by the interest and participation of scores of local citizens are requisites for such a venture. A budget of from 10 to 20 thousand dollars is realistic for such a community occupational survey.

ASSESSING CAPABILITY—If the survey indicates unfilled job needs and predicts sufficient numbers of student enrollees, the next question which must be answered is—What is the capability? Usually, this translates into—Can the necessary funds be made available?

Ordinarily, new laboratories, shops, and much specialized equipment will be needed for an expansion into semi-professional and technical education. In contrast to the provision of a standard classroom for teaching history to 40 students (which might cost $25,000); the provision of an engineering technology laboratory with 20 stations might easily run to $100,000 and still have only the basic, minimal equipment. A "student station" in a traditional biology class might

cost only about $500, whereas a student station for dental office assisting could easily run up to $3,000. These are comparative *capital outlay* costs.

In terms of annual unit *operating* costs, a "transfer-oriented" junior college can have a fine program for a $700 unit cost; while a comprehensive community college with a broad program of semi-professional and technical education is more likely to have a unit annual operating cost approaching $1,000. Records kept on Associate Degree Nursing programs indicate that many of these approach a unit cost of $1,600 or more.

Consequently, it is highly important to face squarely the capability issue and decide to offer the kind and number of courses which can be done well, rather than spreading effort too thin and ending up with a large number of poorly staffed and poorly equipped instructional programs.

IMPORTANCE OF GUIDANCE—The entire structure of a comprehensive community college rests on a foundation of guidance and counselling. The phrase "open-door college" refers to admission to the college, not to admission to any course or curriculum the student may desire. Matching the abilities and aspirations of students with the established standards of rigor of courses and programs requires a quality program of testing, guidance, and counselling, as shown on the flow chart on page 38.

STRUCTURING THE CURRICULUM—It has been emphasized that associate degree occupational education programs are *not* job training programs, but educational programs. They typically consist of the following kinds of content:

General education.....	15–20 hrs.	25% (of a 64–70 credit hour program)
Supporting technical and theory courses.....	15-20 hrs.	25%
Specialized occupational courses.....	30–40 hrs.	50%

THE CORE CURRICULUM IDEA—There is growing acceptance of the core idea in curriculum planning for occupational education.

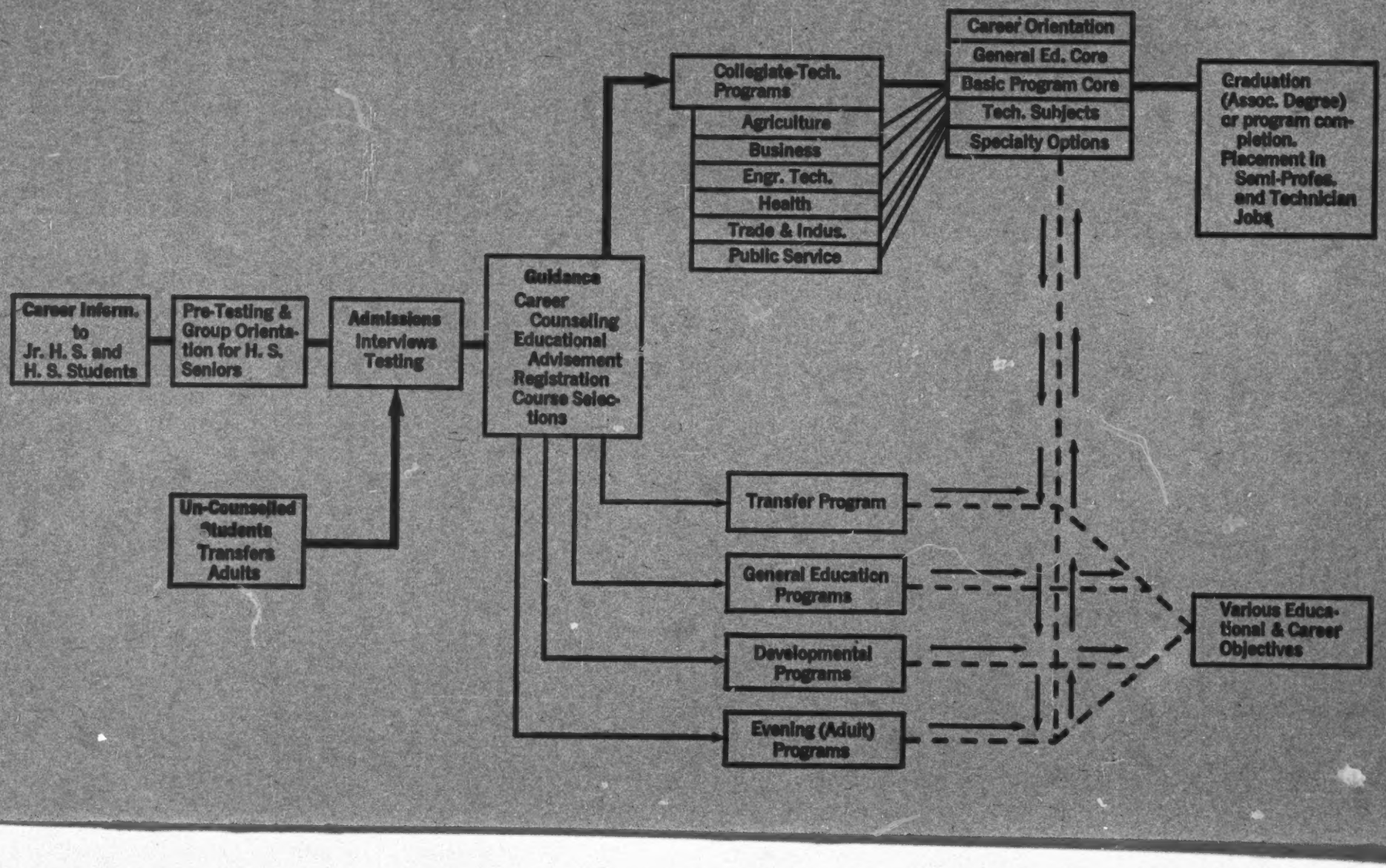
To carry this idea a bit further, let me illustrate how the core concept can be used to structure a total program of occupational education for a community college.

A basic core of general education courses should be required of all students. Each "family" of occupational fields then has a sub-core of supporting theory and technical courses. Finally, each separate occupational field will have its own group of specialized technical and skill courses, usually comprising nearly one-half of the total credit hours.

The advantages of the core curriculum concept are many. Let me mention a few:

1. A basic level of attainment in the "common learnings," and in supporting technical and theory courses is set for all. Employers can thus be assured that graduates of such programs have the potential for future growth with the company or the institution.
2. Problems of scheduling and class size are minimized.
3. Better assignment of instructors may result.
4. Students may switch from one specialized field to another within the

Flow Chart — Suggested Guidance Program Comprehensive Community College



same "family" at the end of the first year, with minimum loss. Changing to a completely different occupational field is possible, without serious loss.

5. When junior colleges cooperate regionally on such a core idea, there are advantages to students and employers throughout the area.
6. Instructional costs, which are quite high in many occupational fields, may be reduced somewhat.

HEALTH OCCUPATIONS TECHNOLOGIES—To give some beginning emphasis to the family of health technologies, with which you are particularly concerned at this conference, let me close with a bare introduction to the problem of curriculum planning for this family of occupations.

First of all, the recruitment and selection of students must be carried out with full knowledge of the level of rigor of the instructional program. With the exception of practical nursing, which is a one-year non-associate degree program, the health technologies require students of fairly high academic ability. Junior colleges which have been offering successful work in the paramedical occupations for years find that, in general, the following attributes are necessary for student success:

1. Ranking in the upper half of the high school graduating class.
2. Demonstrated interest and at least fair ability in the sciences, particularly the life sciences.
3. Performance at or above the 40th percentile on such standardized tests as the SAT battery or the SCAT test, based on national college freshman norms.
4. Dependability and a sense of responsibility of the highest order.

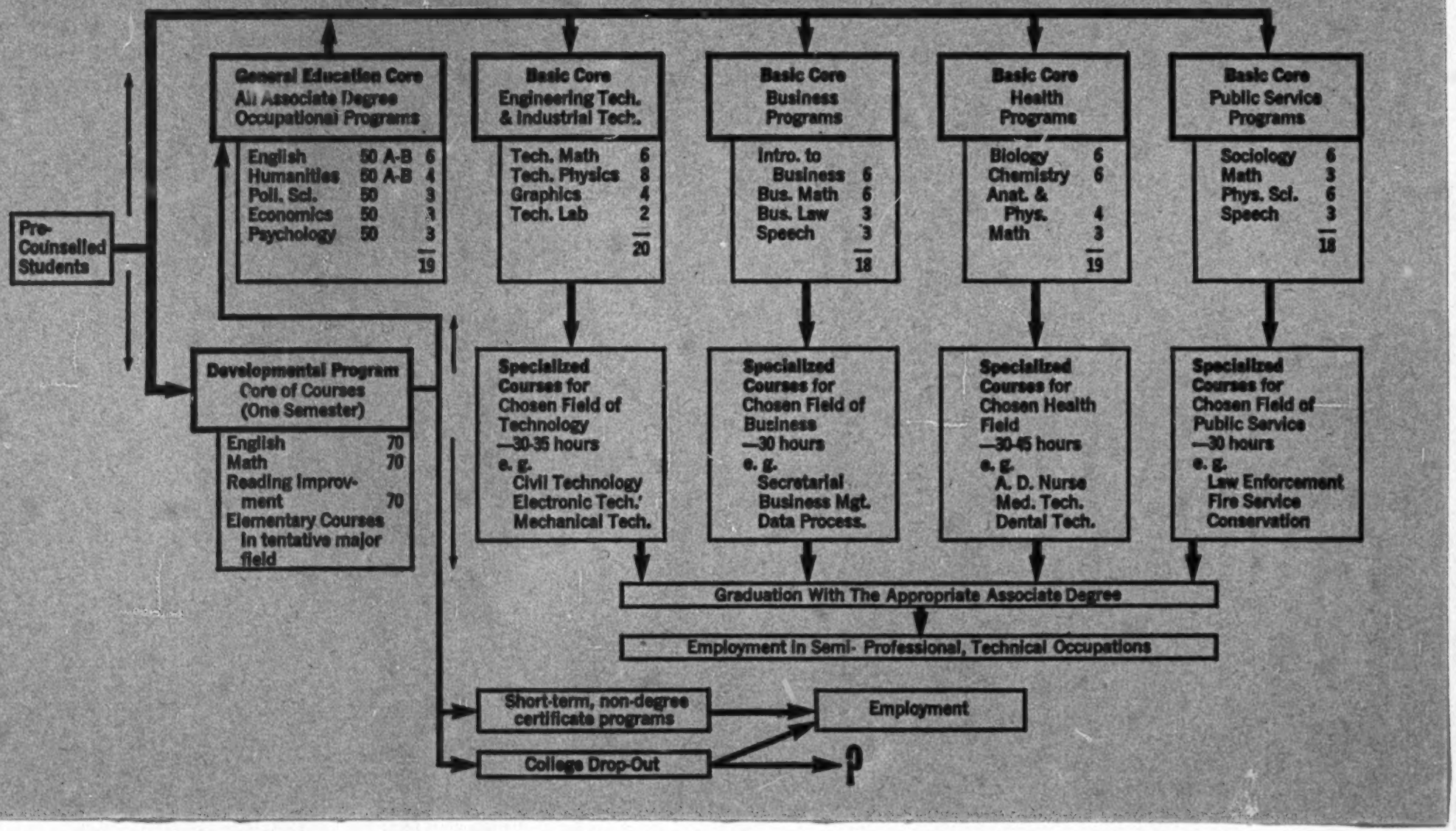
In addition to the SAT and SCAT tests, which are merely indications of one's ability to cope with the common academic subjects, some colleges give dexterity tests and psychological or personality tests to applicants for paramedical programs. Certainly, a complete physical examination is to be recommended in the case of all applicants.

The General Education Core (see chart on page 40) provides a good sampling of the common learnings on a college level, and serves too as a screening device to predict performance in the chosen major field. The Health Program Basic Core as indicated is not intended to be inflexible. In some cases (say X-ray technology) physics might replace chemistry; or (for a psychiatric technician program) sociology might replace the mathematics. Every student presents an individual career counseling problem, and the "core concept" merely aids counselor and student in planning a proper program.

The courses of the "Specialized" block are planned carefully with the assistance of professional associations, advisory committees, consultants, and the faculty of the particular department at the college. In some cases, state standards for licensure have to be met, and regional and national groups may get into the act for accreditation purposes.

CONCLUSION—Community or junior colleges (by either name) are responsive to educational need. Despite my not-so-gentle needlings on earlier pages, I can assure you that the interest of most junior colleges in paramedical education is not ephemeral. Many community colleges are ready and anxious to initiate educational programs in the health technologies. The American Association of Junior Colleges recently funded a study by Robert E. Kinsinger which resulted

Suggested Core Curriculum Plan
Community College Associate Degree
Occupational Education Program



in the publication, *Education For Health Technicians—An Overview*. The Association has assigned a major responsibility to one of its full-time staff members, Mr. Kenneth Skaggs, who is in the audience, to conduct research, plan conferences, and assist community colleges in curriculum development for the paramedical occupations.

The Kellogg Foundation has had a long-time interest in health education, and for the past several years has funded junior college leadership programs in ten centers distributed over the entire country for the purpose of training junior college administrators for the comprehensive junior college. An in-depth study of paramedical education is just being completed in New York State, and initial steps have been taken by your speaker, in cooperation with the Michigan Health Council and Michigan's thirty community colleges to get an action program started there.

To be sure, not many curriculums for the education and training of *mental health* workers have as yet been set in motion, and that is why we are here. Let me commend the Southern Regional Education Board for convening this conference, and charge all of you with the responsibility to forge some new and workable plans during these three days. I foresee increased and continuing cooperation ahead between community colleges and the medical profession. A new symbiosis is in the making, and we can give it a good start by our deliberations here. With the allied health professions ready to participate, I have no doubts at all about the community colleges.

CHAPTER 6

HISTORY AND PROBLEMS OF THE ASSOCIATE DEGREE PROGRAM IN NURSING

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In the letter of invitation to participate in this Conference Dr. Penningroth said the lead expressed by the nursing profession in the development of the ADN programs suggests a model with implications for the Conference. This invitation was irresistible. In the thirteen years I have been involved in the development of this new type of nursing program I have never had occasion to present it as a model. It is a privilege to share with you a little of the history of this development and also the problems encountered as nurse educators struggled to gain acceptance for a nursing program that was a radical departure from tradition.

THE DEVELOPMENT OF ADN PROGRAMS

The proposal that nursing become part of the curricular offerings of Community Junior Colleges was made in a 1950 doctoral project entitled "Education of Nursing Technicians." (1) The author was Mildred Montag and the degree granting institution Teachers College, Columbia University. The proposal was based on the recognition that the functions of nursing were changing and becoming more complex. In Montag's words, "The functions of nursing can be said to be on a continuum or as having a spectrum like range." (2) At one extreme of the spectrum Montag sees those activities that are very simple and that serve to give assistance to the nurse or the physician. These assisting activities can be carried out by nurses' aides who can be prepared on the job or in short vocational courses. Montag said the functions at the other extreme of the spectrum "are those which are extremely complex and require a high degree of skill and expertness acquired through long periods of training." (3) Nurses who assume responsibility for the complex functions at this extreme of the spectrum, she said, needed preparation of a professional type in colleges or universities.

In the middle of the spectrum lies the main volume of nursing that is done in hospitals, clinics and similar agencies. The functions performed in this portion of the spectrum Montag described as semi-professional or technical. She believes that "instruction and training are needed to perform these functions and because of the character of the instruction and training needed it can be carried on most effectively and economically within a school." (4)

A new worker in nursing was proposed in this doctoral project. This worker would have "predominantly semi-professional or technical functions and, therefore, semi-professional or technical training." (5) The suggested name for the new worker was nursing technician. (This title was rejected by the ma-

jority of nurses.) Because semi-professional or technical preparation was within the purpose and scope of Community Junior Colleges, and technical institutes, it was proposed the program to prepare this worker be part of this institution.

A study designed to test the proposals of this doctoral project was subsequently developed into the Cooperative Research Project in Junior-Community College Education for Nursing. The research was made possible through a grant of $110,000 from an anonymous donor. The project was established within the Division of Nursing Education, Teachers College, Columbia University in January 1952 and continued until 1956. The project enlisted the cooperation of seven carefully selected junior-community colleges and one hospital school in developing and setting up an entirely new program in nursing within the framework of the two year college. The purpose of the Cooperative Research Project was to develop and test a new type of program preparing young men and women for those functions commonly associated with the registered nurse. The aims of the project were concerned primarily with the graduates of the new type of nursing education program. It was hoped the graduates would: a) qualify for the registered nurse license, b) meet the Community Junior College requirements for the associate degree, c) perform technical or semi-professional functions at the registered nurse level, d) be prepared for beginning practitioner positions, and e) on graduation, be prepared to *become* competent nurses rather than *be* fully competent. (6)

Evaluation of the graduates from the educational institutions involved in the Cooperative Research Project was an integral part of the project. The purpose of the evaluation study was to test three hypotheses: a) the graduates of the pilot programs qualify for the registered nurse license on the state board licensing examination, b) the graduates of the pilot programs are prepared for staff nurse positions, and c) given some work experience, the graduates of the pilot programs perform the functions of the staff nurse as well as graduates of other types of programs. (7)

Some of the conclusions drawn from the evidence collected during the Cooperative Research study were: a) nurses able to carry on the functions commonly associated with the registered nurse can be prepared in the Community Junior College nursing program, b) nursing programs of this type can be set up as integral curriculums in junior and community colleges, and c) Community Junior Colleges can finance these programs within the financial structure of the institution. (8)

This research project was watched closely by nurse educators and also junior college administrators. Even before the results of the research were announced numbers of Community Junior College administrators were interested in starting this type of nursing program in their own institutions and sought help to do so. There were three main sources of assistance available to them: a) the American Association of Junior Colleges, b) the National League for Nursing, and c) the W. K. Kellogg Foundation.

The AAJC published articles about this new program in its national magazine, *The Junior College Journal*. The association also co-sponsored workshops with the Cooperative Research Project of Columbia University and the NLN. At these workshops college administrators were invited to hear up-to-date reports on what was happening in the project. The AAJC and the NLN established an inter-organization Committee on Nursing Education. This committee in 1955 formulated a statement of "Guiding Principles for Junior Colleges Par-

ticipating in Nursing Education." (9) The statement was widely used by college administration and nurse educators interested in starting nursing programs.

The NLN is an association whose purpose is to improve nursing services and nursing education and to accredit educational programs in nursing. In 1955 the NLN established a consultation service supported by foundation grants, for the purpose of providing individual guidance to administrators of Community Junior Colleges who were interested in initiating, or contemplating the inauguration of ADN programs. A foundation grant from the Sealantic Fund to the League in 1958 underwrote a four year project for the purpose of giving assistance and support to associate degree nursing programs, and to encourage the sound development of new ADN programs by working with Community Junior Colleges, state boards of nursing and citizens' groups. The consultation team for this project consisted of a nurse educator and a junior college educator. The NLN also published materials relating to this new type of program. In 1961 for instance, there was the "Report on Associate Degree Programs in Nursing." (10) There were also frequent articles in the official magazine of the association, *Nursing Outlook*.

The W. K. Kellogg Foundation supplemented the activities of the AAJC and the NLN in 1959 by committing $1,738,107 to four states: California, Florida, New York and Texas. Major aspects of the program selected for financial support in these four states included: a) pre-service and in-service education for faculty, b) consultation services to Community Junior Colleges through the universities and state departments of education, c) establishment of a curriculum demonstration center in each of the states, and d) financial aid to selected colleges for a pre-planning year prior to the admission of students to the nursing programs. A report of the four states project was published in 1965. (11)

INCREASE IN NUMBERS OF PROGRAMS

Students were admitted to the first two ADN programs in 1952. The total number of programs to this date is nearly 180. It is known that many more programs are in the planning stage. The ADN program is now recognized as one of several types of programs that prepare personnel for the occupation of nursing. In 1965 the American Nurses Association published its first position paper on education for nursing. The position states that "minimum preparation for beginning technical nursing practice at the present time should be associate degree education in nursing." (12)

A noted nurse educator has this to say about the status of the ADN programs:

> The future of ADN programs looks bright, indeed. In contrast to the slow development of other types of nursing education—where changes come about more as a result of economic and other social pressure than by creative design of educators—the development of Associate Degree programs stands as a beacon light to encourage nurse educators with respect to both a new process of development and to the resulting new type of program. This new program did not develop merely through trial and error but was designed in accordance with educational principles, bringing to bear on nursing and nursing education, the results of research in the related fields of higher, professional and technical education, with full awareness of the changing directions of health, educational and other social needs. By focusing exclusively upon the educational task and the clinical as well as laboratory aspects of nursing courses, many prob-

laws that have long shackled schools of nursing were avoided. The employment success of the ADN graduates have been demonstrated in hospital staff nurse positions. (13)

The development of this new approach to the education of nurses has not been without problems. I will identify these and discuss them briefly.

PROBLEMS ENCOUNTERED IN THE DEVELOPMENT OF ADN PROGRAMS

A. *Scarcity of qualified faculty.*

1. There was no pool of prepared nurse educators to administer or to teach in the developing programs.
2. There was no agreement among the graduate programs in nursing concerning the content of the educational program to prepare these personnel.
3. The orientation and experience of the majority of teachers of nursing had been in non-collegiate institutions, the hospital controlled schools of nursing. Some teachers have experienced difficulty in becoming oriented to the philosophy and purposes of the Community Junior College and have had problems in developing a curriculum in nursing within this framework.

Quantity and quality of faculty remain our most serious problems. There is general agreement that teachers of nursing in ADN programs should have at least preparation at the masters' level with a major in nursing and with competence to teach in a clinical nursing area. There is also consensus that these teachers should have had some exposure to ADN programs, either through formal classwork, seminars, workshops, or planned visits to existing programs. There is also recognition that the nurse faculty must have an understanding of the institution offering the program, that is the Community Junior College.

B. *Utilization of the graduates of ADN programs.*

1. The ADN programs prepare nurses to give direct care to patients. The program excludes preparation for managerial or administrative tasks.
2. The graduates of these programs are prepared to *become* competent through further supervised experience in nursing.

Employers of the ADN graduates have not always placed these workers in the positions for which they have been prepared. This may in part have been because nursing service was not ready to utilize technical workers in nursing. Also some nursing service administrators expect a beginning nurse to function as effectively as a nurse with years of experience. There is a need for continuing communication between the college preparing nurses at the technical level and the future employers. Montag says, "It is the function of nursing education to produce personnel who know good nursing and who are prepared to make changes in the nursing care of patients. Nursing service must be prepared to accept and use the several types of personnel in nursing according to their abilities and their differences, and to advance nursing by using each worker to the limit of his ability." (14)

Nursing service administrators are becoming aware of this need. As one has said, "The graduate of the two-year program has acted as a catalyst in the examination of problems and needs of young graduates . . . . Because the needs of the two-year graduates are so obvious, and we see her in comparison to two other types of basic program graduates, our attention is focused more clearly on the needs and problems of all nurses." (15)

C. *Selection of content for the program of studies.*

1. The general curriculum design requires a new approach to selection of content and teaching, particularly in the courses of nursing. Approximately one half of the credits are in nursing and one half in the general education areas of natural sciences, social sciences and the humanities. A broad fields approach is utilized for the nursing courses and each semester of the program includes at least one lecture-laboratory course in nursing. Deciding what to include in the nursing courses has been and continues to be a challenge to the teachers in these programs. The appropriate content and necessary learning experiences for the preparation of the technical level nurse is still being identified.
2. Identifying the most valuable courses for the general education component of the program requires continuing study. It has not been difficult to select suitable courses in the humanities, including English, or in the area of social sciences. The area of natural sciences has presented more of a problem. Many science teachers are more concerned about developing science courses to meet the needs of transfer students than in developing science courses for the occupational curricula. Sometimes new science courses have been developed, not alone for students studying nursing, but open to other students in the health field or to those needing general education credits in science. Some teachers of natural science have enthusiastically tackled this challenge and some interesting courses have been developed.

D. *State boards of nursing regulations.*

In most states the board of nursing is the legal administrative agency that approves programs of nursing and admits candidates to the registered nurse licensing examination.

1. When the ADN program was started in 1952 many boards had regulations for educational programs that were stated in terms of weeks and clock hours of instruction. These regulations had been developed for non-collegiate institutions, the hospital controlled schools. In some instances it was difficult to get permission to plan the curriculum within the college credit system.
2. Many states also had either a law or board regulation that required a nursing program to be three years in length. In some states the law or regulation was easily changed but in others it was a difficult task to get the necessary changes that would permit the college to develop a nursing program within the college framework of two academic years. In the majority of states changes have come about and it can now be said that most boards of nursing respect the characteristics of this Community Junior College program.

E. *Provision for a planning period.*

1. The nursing program is planned as a whole rather than as a series of isolated courses.

This kind of planning requires time and demands that at least the nurse administrator, and hopefully one or two teachers of nursing, be appointed to the faculty and be on the job prior to the admission of students. Experience has demonstrated that the nurse administrator should be on the job at least six months prior to the admission of the first class. During the planning period the nurse administrator not only spends time on curriculum development but also makes decisions concerning what coop-

erating hospitals will be used for what learning experiences. This involves her becoming oriented to the cooperating institutions and also orienting personnel in the hospitals to the philosophy and objectives of the ADN program.(16)

2. Colleges have not been accustomed to having faculty so far in advance of the admission of students and some colleges have had no method of financing personnel not involved in teaching. In some instances small grants to cover salaries from foundations, particularly W. K. Kellogg, helped some colleges. Today it appears to be less of a problem as college administrators have found ways and means of financing faculty for a planning period.

F. *Cost of the program.*

The cost of the program was identified as the most discouraging factor administrators had to deal with in a recent doctoral study that involved 310 two year colleges interested in ADN programs.(17) About 75 percent of the respondents from colleges conducting nursing programs said the program was more expensive to operate than other programs in the college. About half of these respondents based their replies on an estimate of costs and a third on a systematic study of costs. In spite of this concern for operating costs the data revealed that 82 percent of the colleges offering nursing were supporting the program in the same way as all other programs in the college. However, over half of these colleges had received a financial subsidy for the early years of the program, most frequently for a one year period.

The nursing program is costly to operate, not because of equipment, but because of the ratio of students to faculty. There is still no agreement on what this ratio should be. Various teaching methods are being developed to determine if it is possible to increase the number of students taught by one teacher in the clinical nursing laboratory; these methods include teaching by television and using group assignments in the care of patients.(18) Continuing research is needed.

G. *Accreditation of the ADN program.*

Since 1952 the accreditation of programs in nursing has been the responsibility of the NLN. Although the number of ADN programs has grown rapidly, the demand for accreditation of these programs by NLN has been minimal. This is related to the opposition of the AAJC to specialized accreditation. The passage of the Nurse Training Act of 1964 requiring that a nursing program be accredited by the NLN to be eligible for federal funds, brought the issue into sharp focus. The AAJC sought to change this requirement in the act, but at this writing the NLN remains the officially approved national accrediting agency for all nurse education programs seeking funds under the Nurse Training Act of 1964 as amended by the Health Professions Educational Assistance Amendments of 1965.

Some states are taking strong action in relation to specialized accreditation. For example the Florida Junior College Board has a policy which forbids junior colleges from applying for specialized accreditation. In other states, such as New York, the decision of whether or not to apply for NLN accreditation is the prerogative of the individual college.

H. *Lack of support from nurses and nurse groups.*

In the doctoral project, previously referred to, it was found that it had not been nurses or organized nurse groups that had initiated the idea the college

inaugurate a nursing program; the initiators had been college administrators. I could continue enumerating problems but I believe this list gives some idea of the problems encountered when there is an attempt to prepare a new worker for an occupation through a different educational approach.

There have been some interesting outcomes as a result of this new approach to the education of nurses.

RESULTS OF THE VENTURE IN EDUCATION

1. The Community Junior College has been shown to be an appropriate setting for the education of the technical nurse. This additional resource is a means of adding to our nurse supply. As two year state college systems are developed and strengthened throughout the United States we can look forward to the starting of more ADN programs and an increasing number of graduates entering the job market.

2. The ADN programs have attracted a new source of applicants to nursing; students who want to go to college and at the same time to study nursing, and the more mature women who have raised a family and are now ready to prepare for a second career. A larger number of men students have been attracted to these programs than to the hospital controlled programs.

3. The development of orientation and in-service education programs for the graduates of the ADN programs has alerted hospital nursing services to the needs of all beginning graduates. In addition the development of a technical level nurse has increased the interest and concern about the appropriate utilization of all workers in the occupation of nursing.

4. For the first time in the history of nursing education the cost of educating a nurse is beginning to be seen as a legitimate cost of the taxpayer. The financial burden, previously born by sick patients in hospitals, is now shifting. As hospital boards of trustees take a more searching look at operating costs, the expense of conducting a school of nursing is being seriously questioned. Increasing numbers of hospital boards are turning to two year colleges to assist them with this problem. The education of nurses is a legitimate function of an educational institution not of a service institution. Hospitals will continue to make an important contribution to the education of nurses by opening their doors as laboratories for the teaching of nursing.

The development of the ADN program is a story of a creative proposal, the testing of the proposal through a cooperative research study, the dissemination of the results of the study findings through the supportive efforts of organizations, associations and individuals, and the cooperative efforts of interested individuals in implementing the findings. The result has been a major break-through in the preparation of nurses.

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CHAPTER 7

THE ISSUES BEFORE THE CONFERENCE

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My assignment this afternoon is to point up in a summary fashion some of the major issues before this conference. Thanks to the excellent presentations which have been made already by Dr. McPheeters, Dr. Harris and Dr. Schmidt, my task is fairly simple. As Dr. McPheeters made clear, there is a need for more trained manpower in the burgeoning field of mental health. As Dr. Harris made clear, two-year community junior colleges are making an increasingly significant contribution to the preparation of "middle level" personnel in many occupational areas. Dr. Schmidt has given us a case study of one particular occupational field—nursing—which suggests some of the possibilities and also some of the problems which are encountered when two-year community college programs are developed in one of the health professions.

I hope that all of you have taken the time to read the set of background papers which were sent to you in advance of this conference. If you have not, I suggest that you do so this evening. Not only are they colorful in their appearance, they are thought-provoking in their content. Taken together, the series of background papers and the series of formal presentations which we have heard today constitute the sum total of the ideas concerning the conference topic which we will bring to you. The rest of the job is yours. As Dr. Penningroth indicated this morning, the group assembled in this room represents a cross section of the best people in the field of mental health and in the field of the community junior colleges in fifteen Southern states. In both groups there are important sub-groups represented, including academicians who study *about* either mental health or community-junior colleges, state level practitioners who either administer or coordinate state systems of mental health or community college programs, and local practitioners who are directly involved in the day-to-day tasks of providing either mental health or community college services. The possibilities for a cross-fertilization of ideas in a group like this are tremendous. Whether this actually happens will depend upon you.

The structure of this conference for most of the two days remaining is a series of discussion group sessions interspersed with reporting sessions at which the total group will reconvene and have a chance to hear and comment upon interim progress reports from the discussion groups. The discussion groups not only divide us up into groups small enough for a genuine exchange of ideas; they also are arranged so as to bring together people from the same state. We are quite ready to admit that our purpose in doing this is to enhance the chances that this conference will result in some active follow-up in at least some of the states. This is more likely to happen, we think, if the people who spend their time talking to each other during the next two days are the same people who have it within their

power, at least to some extent, to do something about those ideas which seem applicable to the needs and possibilities in their particular state setting.

So much for group dynamics; what are the issues to be discussed? The program before you suggests a major discussion topic for each of the four small group discussion periods. These are calculatedly general enough to allow plenty of flexibility, but we hope that in a general fashion you will adhere to them, because we think they suggest a natural progression from a statement of the problem to a consideration of possible solutions.

This afternoon the discussion topic is the need for mental health workers—in other words, a consideration of whether a manpower problem does, in fact, exist in our states, and if so, its extent and its characteristics in terms of the types of manpower and womanpower needed.

The discussion period tomorrow morning is designed to delve further into the characteristics of mental health manpower needs as they relate to the possibility of two-year community college programs. Which parts of the manpower needs might be met through two-year community college programs? From the point of view of the needs of the mental health field on the one hand, and of the interests and capabilities of the community-junior colleges on the other, what model or models suggest themselves? There are a number of possibilities, and some of them are contradictory.

For instance, should the line of attack be aimed at meeting the specific needs of specific potential employers of two-year graduates as they are individually defined in each community, or should there be some attempt to develop a state-wide or nationally acceptable pattern leading toward the emergence of a new occupational identity which would become generally recognized and permit fairly free movement of graduates from community to community and from state to state.

If only local needs are to be met, there is likely to be a great deal of diversity among programs since each presumably would be developed jointly by the community college and a specific agency such as a hospital, community center, or school for the retarded, to meet the specific needs of that program at that particular point in time as they are perceived by the program's *current* administrators. In many instances this undoubtedly would have more in it of manpower training (or retraining) than of what we like to think of as education, and the specific training offered probably would fluctuate over time with changing job opportunities and changing manpower needs in the employing agency. A good deal can be said both pro and con about this concept of occupational preparation.

The other possibility—the development of new occupational fields which would be recognized by more than a single employer—also would involve collaborative efforts between mental health people and community college people, but the collaboration would extend beyond just the community and would include state agency people, state professional associations, and sooner or later national agencies and professional organizations as well.

At the state level, of course, consideration must be given to how many community colleges should offer programs related to mental health occupations and to the differentiations and specializations which should be encouraged among the institutions which do offer such programs.

Another question which arises when one begins to consider possible models for two-year mental health workers is the matter of training specialists as opposed

to training people for sub-professional entry into a specific occupational field such as vocational counselling, physical therapy, etc. And these questions promptly break down into a number of sub-questions. For instance, if you choose the route of training for specific sub-professions, do you do so on a strictly terminal basis which precludes subsequent transfer of credits to a senior institution's baccalaureate program in the same professional field, or do you design a program which can enable a student to transfer to a senior institution should he choose to? Directly related to this, of course, is the tendency of already established professions to resist the establishment of new professions in closely related fields. Nursing is fighting this battle at the present time, with various forces arrayed on each side of the question. And what about the practical question of the individual institution's ability to provide a wide variety of specializations instead of concentrating upon a core curriculum in the field of mental health?

The alternative of preparing generalists also introduces a variety of sub-questions. Is the term "generalist" in this context meant to be a person who has been given a core curriculum relevant to the field of mental health upon which the employing agency will build through post-employment in-service programs designed to develop a sub-professional specialist? Or is the mental health generalist a new breed of occupational cats—a sub-professional person who can be used in various places throughout an agency without ever actually becoming a specialist himself, even at the sub-professional level?

These questions are so basic that they cry out for thoughtful consideration and for whatever degree of clarification the discussion groups can arrive at. It is altogether possible, of course, that in the long run the answer to some of these questions will not be to choose between them, but to have both kinds and make use of their quite different prospective contributions. At this juncture, however, any community college which enters into the preparation of mental health personnel will need to start with a specific and delimited objective in mind, and therefore it will have to make a decision on these questions.

Without in any way having exhausted the issues associated with the basic question posed for the second of the small group discussion session, the practical considerations related to how a community college makes the kind of choice to which I have just referred leads us to the topic of the third set of discussion groups—the problems and obstacles to be overcome.

One whole series of issues in this area has to do with the way in which a decision gets made as to whether a particular institution should offer a mental health occupational program at all, and if it does, what type of program it should offer. I can think of two disastrous methods for making such decisions: one is for the community college simply to decide to offer such a program and publicly announce it; and the other is for some mental health agency in the community to unilaterally design a program and announce that the local community college ought to teach it.

Sad experience in a number of occupational and professional areas has clearly shown the necessity for close collaboration between both groups—the community college and potential employers—in the development of any occupational program. The extent and type of need must be measured, and potential employers must be identified in a fairly precise manner. The capabilities of the community college must be assessed. The degree of interest must be determined on both sides, and so must the degree of interest on the part of potential students.

The latter also involves determining who the prospective students would be: recent high school graduates, current agency employees who are interested

in upgrading themselves, or middle-aged residents of the area who see the possibility of preparing themselves for interesting employment. Sometimes these things form vicious circles in which there is no student interest without prospects of employment, and there are no budgeted positions in the agency for a non-existent specie of middle-level worker. Breaking this circle can be difficult.

There are also problems associated with deciding upon the most appropriate type of curriculum, and there are serious problems associated with finding faculty to teach a new occupational field which almost literally must be created as a field at the same time it is being taught as a series of courses. Where do you start? Sometimes in a specific local community where there are interested people in both the local community college and the local mental health agencies. Sometimes at the state level, through cooperative planning and development involving the state community college and mental health agencies, although in this case local people also need to be involved because it is they who will have to attempt to implement whatever is agreed upon. Sometimes one starts at the regional or national level through either governmental or professional organizations. There are advantages and disadvantages to starting in any of these ways, but the relative advantages are apt to differ substantially from one state to another.

Which leads up directly to the topic of the final discussion session: What are the next steps by mental health agencies, by community colleges, and by SREB? If we have really gotten anywhere in the first three discussion sessions, this fourth one will be of crucial importance because it will tell the tale as to whether these three days have been anything more than an interesting intellectual exercise. If action is needed, its form should be discussed, and conversely, of course, if the idea of two-year programs for mental health workers is not feasible, that last discussion session is the time for a final recognition of that fact and a positive conclusion that there should *not* be any further action toward the development of such programs. The greatest tragedy that could come out of this conference would be for us to come to a genuine understanding of the extent to which there actually are practical possibilities for community college programs to prepare mental health personnel and then leave this conference and proceed to act as though we have never experienced that understanding.

CHAPTER 8

PATIENT NEEDS AND TRAINED HELPER FUNCTIONS IN THE MENTAL HOSPITAL

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The intent of this presentation is to highlight briefly some of the needs of patients in the typical mental hospital, many of whom are often partially or totally neglected; to point out some of the characteristics of a helping relationship which may be of value in meeting some of these needs; and to suggest some possible roles for a trained helper who is motivated to help patients with psychiatric problems.

PERSONAL NEEDS OF PATIENTS

The personal needs of patients do not differ in kind from those human needs of any of the rest of us who may currently be on the "outside," although they certainly differ in intensity, configuration, and the habit patterns or skills for satisfying them. One might take a list of needs such as Murray's,(1) or the more modern version of Edwards' in his *Personal Preference Schedule* (2). The latter was used for some time at the South Carolina State Hospital in an attempt to assess the personal needs of patients, and was abandoned largely because of the staff's discouragement over inability or lack of resources to meet these needs once they were identified. Perhaps the basis of these needs rests on the need for affection and satisfactory interpersonal relationships, as suggested by Snyder,(3) and love in its broadest sense can be a powerful therapeutic tool.(4)

Another approach to assessing and planning for patients' needs could be made in terms of helping with inadequately achieved developmental "tasks" as outlined by Erik Erikson:(5) trust, autonomy, initiative, industry, identity, intimacy, generativity, ego integrity. This focuses attention on the *personal growth* of the patient rather than merely on symptom removal or reduction.

THE HELPING RELATIONSHIP: THE NATURE OF "THERAPY"

According to Wolberg,(6) all therapies provide the client with:

1. Emotional support.
2. Cathartic release.
3. Help in handling stress.
4. Help in altering defenses.
5. Help in re-evaluation of self.

The "mental" patient may present severe and complex problems which may make extended professional training on the part of the staff most helpful, but

surely these sorts of human needs can and are being met by many persons without a great deal of special training. This is clearly pointed out by Alexander:(7)

> Everyone who tries to console a despondent friend, calm down a panicky child, in a sense practices psychotherapy. He tries by psychological means to restore the disturbed emotional equilibrium of another person. Even these common-sense, everyday methods are based on the understanding of the nature of the disturbance, although on an intuitive and not on a scientific understanding.

The nature of the helping relationship has been well set forth by Rogers:(8) trustworthiness on the part of the helper; unambiguous communication; attitudes of warmth and respect; a sense of personal identity; empathy, acceptance, sensitivity, freedom from evaluation; and acceptance of the other in his process of becoming or growth. This is reminiscent of Fromm's (9) characterization of the basic elements of love: care, responsibility, respect, and knowledge. Certainly professional training can furnish the last, but the other three qualities are not easily acquired.

What sort of person possesses these essential characteristics to be personally helpful? Pretty clearly, it is one who is healthy himself. This is in part the reason behind requiring a didactic personal analysis as part of the training in traditional psychoanalysis. The healthy or congruent (10) person stimulates healthy attitudes in others, just as "integrative" behavior in the teacher induces integrative (constructive, healthy) behavior in the child.(11) Potential helpers then probably exist in greater numbers than we have been accustomed to recognizing once we cease to limit our view to professionals with extensive training. Evidence is beginning to come to light that relatively healthy people with limited training can have very significant therapeutic roles.

TRAINED HELPER ROLES IN THE MENTAL HOSPITAL

A number of very important task functions or roles are desperately needed in the mental hospital. Many must currently be carried out by highly trained personnel because professionals are reluctant to delegate them or because there is no one else to do them; others remain unfilled and neglected. Five categories of helping roles are proposed; not all may seem of great significance or command respect and status, yet the principles of milieu therapy suggest that *all* persons in the environment have potentially important therapeutic functions.(12)

1. *"Housekeeper"*

   Such a person carries out such basic necessities as making beds, taking trays to patients, cleaning, assisting patients with grooming, taking them to appointments when they cannot go alone, keeping records and doing other clerical work. Such a person's role can be enhanced through training, but such duties hardly seem to require a professional nursing degree, or even special attendant training.

2. *"Assistant" to a Professional*

   This role has already been developed in many hospitals. The assistant is assigned to and supervised by a professional, such as a social worker, and may take case histories or related duties. Other possibilities are test administration and scoring for the psychologist, data collection, and tabulation (often involving patient contact) for the researcher. For several

summers, the Vocational Rehabilitation Project at South Carolina State Hospital has utilized college students to assist with activity therapy programs such as music therapy, occupational therapy, home economics, and the like, and these untrained individuals have become quite effective after a brief orientation and with supervision by regular staff.

3. *The "Buddy" Role*

This type of role is frequently carried out by volunteers on a sporadic basis, but could be conducted on a nearly full-time basis. The helper is assigned to one or a very few particular patients at any one time as a friend and companion. On a practical basis, the buddy can accompany the patient or small group to town for needed shopping or services, entertainment, employment interviews, and the like. The close, continuous contact of the helper can serve as social support, ego building, a model for identification, and the deliberate or unwitting acquisition of social skills and healthy interpersonal attitudes.

4. *"Skilled Helper"*

This is a person who can combine an existing skill, such as woodworking, electrical repair, typing, or cosmetology with a therapeutic approach. This role is often found in the industrial therapist, but frequently in the mental hospital the person in charge of such technical trades has had no mental health training. Some of this could be supplied by undergraduate college courses along with the technical training.

5. *Milieu Therapist "Assistant"*

Often, wards in mental hospitals seem to "run themselves"—ward crises are handled by whomever can be contacted at the time, be it head nurse, psychologist, physician, or other administrator—yet there is no conscious therapeutic milieu program. A helper trained in principles of basic mental health and social psychology could be of great help in raising ward morale through various group methods, such as patient government and informal discussion groups, with professional assistance as appropriate.

Undoubtedly, these suggestions are incomplete and, hopefully, they will stimulate other possibilities in the reader's mind. For years, many such roles in mental hospitals have been filled by non-professionals, but out of desperation rather than deliberate intent, and since the person was regarded as a "temporary stopgap" he was usually given no training in mental health principles. Now we begin to see that these and similar roles make a great deal of sense; if we can recognize their importance, be willing to yield some of our own professional "prerogatives" and stereotypes for the sake of patient growth, and provide appropriate college and in-service training for "non-professionals" with the necessary basic personal characteristics, the serious drain on professional resources will be partially reduced and patient care substantially improved.

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CHAPTER 9

JOB FAMILIES IN MENTAL RETARDATION

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MEETING EDUCATIONAL AND TRAINING NEEDS OF THE MENTALLY RETARDED

The classroom teacher shortage which presently exists and the even greater shortage which is forecast for the future is well documented. This shortage is present for all areas of teaching, but is most notable in the specialty fields such as mental retardation.

Surveys have indicated that parents whose retarded children have access to community-based programs such as public school education are less likely to seek residential placement. Although the evidence is less clear, research findings also suggest that retarded individuals who receive specialized training, such as that provided by classes for the mentally retarded, make more academic progress and are more likely to adjust in the community as adults.

Faced with the dilemma of the increasing need for various educational and training programs on the one hand, and the increasing shortage for fully-qualified teachers on the other, the only solutions would seem to be to find more efficient teaching methods, or increase the manpower pool. Although we should not ignore the former solution, more immediate "pay-off" seems to favor the latter. This improved manpower pool can be achieved by training a variety of "teacher assistants" or "training technicians" to work in highly structured settings, usually under the supervision of a fully-qualified person.

JOB 1—TEACHING ASSISTANTS IN EDUCABLE MENTALLY RETARDED CLASSES—This job should be differentiated from the "teaching aide" which one finds in a number of public school classes for the educable mentally retarded (EMR). The "aide" usually has received no specialized professional training and functions more as a high-level maid rather than as a teacher. The aide may do no more than supervise or babysit with some of the children while the teacher is working with the rest of the class. The aide may also handle emergency situations, such as taking children to the bathroom or caring for a child who has had a seizure.

The teaching assistant would function as a classroom teacher, but would be supervised by a fully-qualified EMR teacher. With this arrangement, one teacher should be able to carry out some teaching as well as to supervise three or four assistants. Planning conferences with the teacher and assistants would be held each day during which daily lesson plans would be discussed, as well as learning and behavior problems among the students. The teacher would have sufficient free time to circulate among the classrooms to offer guidance to the assistant teachers.

It would be difficult to sort a teacher's duties into those which are easy and those which are difficult. Hence, rather than make the teaching assistant a specialist who takes over some of the "easy" teaching tasks for several classes, it would be better to think of a team-teaching approach, or the full-time assignment of a teaching assistant to a particular class. If the latter were followed, the master teacher would provide the back-up consultation and supervision.

This job, more than those mentioned below, may infringe upon existing laws, policies and traditions of federal, state, and local agencies. If, for example, a state education department requires one certified EMR teacher for each fifteen children in order for the local school district to receive state aid, the approach suggested above might not qualify for aid. As a result, the local school system or parent group would have to provide the additional financial support. A more ideal solution, however, would be for this arrangement to demonstrate its effectiveness so that inappropriate restrictions could be removed.

JOB 2—TRAINABLE CLASS TEACHERS—Mentally retarded children of trainable-level intelligence (IQ 30-50) are being diagnosed earlier and therefore excluded earlier from regular or special public school classes. Most states have adopted permissive legislation which offers state aid to reimburse local school districts for trainable classes. However, most school districts have concentrated on the development of EMR classes and have not accepted responsibility for the trainable child. As a consequence, particularly in the South, a high percentage of the trainable classes are sponsored by parent groups or otherwise privately supported. This development outside the public school system has led to variation in the adequacy of curricula standards and teacher qualifications.

Quite apart from the current inadequacies of many trainable classes, educators are becoming aware of the fact that training given to teachers of normal elementary children or EMR children is not suitable for the trainable-level child. However, there are few teacher training institutions in the country which offer an adequate program to prepare one for meeting the educational needs of the TMR child.

Trainable children are unable to profit from academic training beyond the learning of simple number concepts and the reading of common signs. Their major needs fall in the areas of social skills, self-care skills, and work skills. Few trainable children can become socially and vocationally independent. However, by learning to adjust to the demands of society, to find one's way about the community, and to complete simple work tasks the TMR adult can remain in the community in a semi-protected environment. Supervision may be provided by the handicapped person's parents or by a "half-way" house or boarding home. A sheltered workshop may be needed to provide partial self-support. Special social clubs may be needed to provide recreational opportunity.

Many educators believe that the trainable child should be educated in a home-like atmosphere rather than the typical classroom setting. Here, he could learn such self-care skills as how to eat properly, how to practice good manners, how to handle and care for his clothing, and how to perform simple chores such as bed-making, cooking, and care of the lawn. It might be desirable to have a master teacher to supervise several two-year teachers; however, the above curriculum may be more easily implemented by the specially-prepared, two-year teacher than by a teacher with depth training and years of experience in teaching academic skills.

JOB 3—BEHAVIOR-SHAPING TECHNICIANS—The application of modern learning theory, based upon reinforcement, has demonstrated its effectiveness in programmed learning and in the teaching machine. In recent months, this approach has been utilized with striking effectiveness to teach various skills to the mentally retarded who have not been responsive to the highly verbal and unstructured methods applied to large group teaching such as in the classroom.

The mentally retarded child of pre-school age, as well as the older, profoundly-retarded person, typically presents major problems in management. They have little understanding of spoken language, are frequently hyperactive and often destructive. Because of these characteristics, and their low level of mental development, they cannot adjust in a group situation and require almost one-to-one supervision.

Behavior-shaping techniques based upon the use of reinforcement (rewards) have now been developed which permit the gradual learning of more mature behavior. This ultimately permits teaching these children in small groups. Food rewards must be employed early in teaching the profoundly-retarded person; however, as the person learns, social rewards—such as praise—can be substituted. Although these individuals do not overcome their retardation, they can be taught relatively high-level skills such as proper toilet habits, self-feeding, dressing, and some degree of self-control in group situations. This method offers a step-by-step procedure for gradually achieving these goals.

The behavior technician would be responsible for teaching and supervising a small group of pre-school or older, profoundly retarded in a day-care or residential setting. He would provide training in self-care skills as well as social skills and behavioral control. In addition, he would utilize this method to encourage language development, motor skills, and simple discrimination learning. Depending upon the demand, it would be possible for an experienced behavior technician to train and supervise assistants to work under him. These assistants would focus upon routine, daily activities, permitting the technician to teach higher level skills and concepts.

MEETING NEEDS OF MENTALLY RETARDED FOR DEVELOPMENT AND COORDINATION OF COMMUNITY PROGRAMS

The mentally retarded present many needs which could be met by persons with two years of college and practicum training. The following jobs are based upon the increasing emphasis on providing care and training for the retarded in the community rather than in a residential facility.

JOB 4—EXECUTIVE DIRECTOR OF ASSOCIATION FOR RETARDED CHILDREN—The major contributor to the development of community services for the retarded has been the organization and growth of the National Association for Retarded Children. Every state now has its own organization, as well as every major city throughout the United States. Most of these state and local organizations have an executive director. These individuals are responsible for fund raising, encouraging the development of local chapters, helping the chapters to function effectively, and encouraging the development of programs to meet the needs of the retarded and their parents. In many situations they have responsibility for supervising and coordinating all of the programs sponsored by a state or local group. In this role they must have a broad knowledge of public relations, budget planning, management, and programming for the

mentally retarded. Their job cuts across some of the more specific jobs described above, and their training would necessarily have to be more general, lacking the depth provided in the specialist occupations.

JOB 5—MENTAL RETARDATION REFERRAL CLINIC WORKER—A major need of the mentally retarded and their families is to be referred to the proper source for assistance and at a time when this assistance is needed. Many mentally retarded are not diagnosed until they are in the first or second grade. Many retarded are excluded from school, and their parents do not know about existing day-care centers, TMR classes, or vocational rehabilitation programs. The parents and the child should be informed about services available to them, and the services provided by the various agencies should be coordinated so that people are not lost in the shuffle, but are routed from place to place as the needs change.

One way to meet this need is to establish a mental retardation referral center. The child and his parents could be brought to the attention of the Center whenever retardation is suspected. Counseling could be provided to the parents and they could be directed to the services which appear to be needed. This Center and its staff would not be responsible for diagnosis, evaluation, or treatment, but would be responsible for referral and coordination. The staff could keep themselves informed regarding services available to the retarded. By maintaining a file on the retarded and his characteristics, they could keep their clients moving from service to service as needs change. They could also serve as a catalyst to encourage development of needed services and coordination of services.

JOB 6—HOMEMAKER SERVICE DIRECTOR—Many parents are able to provide the supervision and care their retarded children require unless they encounter unusual illness or injury. The impact of a newborn sibling, or the mother's suffering a coronary, may be sufficient to make them seek institutionalization for a retarded child. Many communities have found that bringing in a homemaker on a temporary basis will enable a family to continue to function satisfactorily until the crisis is past. Although the cost of this service is underwritten by a private or public agency, the family could reimburse this agency according to their ability to pay.

The salaries paid homemakers are generally slightly above the usual domestic wage; however, they are not sufficient to employ expert help. As a result, it is necessary for the director of the service to maintain a program of recruitment and training in order to upgrade the skills of the homemakers. There are certain basic skills of nursing, sanitation, cooking, and child-care which the director would need to know to be able to impart them to those under her supervision. Some of the specialized skills which the homemaker would need to know include the care and feeding of the cerebral palsied child; care and use of specialized equipment, such as wheel chairs and braces; lifting and caring for the nonambulatory patient; and supervising and entertaining handicapped children.

CHAPTER 10

MENTAL HEALTH WORKERS' JOB DESCRIPTION

JEAN GOBERLE, M.D.
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PATIENT NEED	MENTAL HEALTH WORKER'S JOB
1. Comes to see a psychiatrist of his own will, or referred by someone	•Intake interview by checklist or standardized interview, i.e., set of questions given in the same order and with a specific period of time in which to respond (I omitted that a MHW answered the phone inquiry and set up the appointment). a. Admission clerk (MHW) gets information as to insurance and intake statistics. b. MHW escorts patient to his ward where MHW takes and records BP, TPR, Wt. c. MHW checks and marks patient's clothing. •d. MHW does mental status using checklist. e. Medical history, physical and neurological examinations—I don't see how MHW can do at our current stage in medicine—but one day a computer and the patient will do it!
2. Hospitalization	
3. E. S. T.	MHW assists the X-ray technician or actually takes the chest and spine films under the technician's supervision.
4. Urine and blood work, cbc, liver profile	Routine urine and blood samples can be obtained and run by the MHW. In today's laboratory—Coulter counters and auto-analyzers require only careful dilution, handling, and accurate recording of the results.
5. EKG (if over 40)	MHW easily can be taught to do.
6. EEG (if there's a question of organicity)	MHW can be taught this procedure.
7. Psychologicals	MHW can be taught to administer and score but *not interpret* most current psychological examinations.
8. Constant observation and medication given	MHW can be taught most bedside nursing techniques about a junior college level and we are using people with an 8th-grade education to fill this role currently.

9. Dental care	Variations on the dental hygienist and dental assistant would make more available if MHW were taught.
10. Occupational therapy, music therapy, recreational therapy, industrial therapy (While I've only listed them, perhaps all their facets should be touched on, such as greenhouse and the need for horticulturists, sheltered workshop supervisors, etc.)	All of these therapies encompass jobs that now require A.B. or M.A. degrees. If the curriculum were modified, there is no reason why a MHW could not fill any of these roles and, if he later wants more education in that area, be able to use what he has learned from patients and go on to get his degree.
11. Brush up in some courses in preparation for the General Educational Development Certificate (high school equivalency)	Teachers with two degrees and years of experience do this now, but a modified course can teach the MHW to perform many of these functions.
12. A vocation	Vocational Rehabilitation Counselors' qualifications vary from state to state, but there are never enough to reach our largest population—the chronically ill schizophrenic. So, bring on the MHW and teach him enough in two years to help our patients.
13. Psychotherapy individual or group	*On this hallowed term, I'll be hung, but I won't define it. The relationship of doctor to patient, in either individual or a group setting, is not so sacred that it cannot be shared and taught. Here is where I really feel that the criteria in choosing the MHW is important. While I wouldn't settle for a "warm body," neither would I settle for a "cold fish." I feel that an intelligent, compassionate person can establish rapport with another human being, regardless of whether he has an M.D. after his name. All of us have seen one patient help another when all of our sincerest efforts have failed.
14. A complete medical folder	*The history, mental status, progress notes, and final summary can be dictated by MHW, filed properly and more promptly than waiting on the doctor.

*MHW-Mental Health Worker-role usually assumed by the psychiatrist.

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2. Hospitalization	a. Admission clerk (MHW) gets information as to insurance and intake statistics. b. MHW escorts patient to his ward where MHW takes and records BP, TPR, Wt. c. MHW checks and marks patient's clothing. •d. MHW does mental status using checklist. e. Medical history, physical and neurological examinations—I don't see how MHW can do at our current stage in medicine—but one day a computer and the patient will do it!
3. E. S. T.	MHW assists the X-ray technician or actually takes the chest and spine films under the technician's supervision.
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8. Constant observation and medication given	MHW can be taught most bedside nursing techniques about a junior college level and we are using people with an 8th-grade education to fill this role currently.

CHAPTER 11

GRADUATES OF COMMUNITY COLLEGES: A MANPOWER RESOURCE FOR MENTAL HEALTH SERVICES

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INTRODUCTION

There is an increasing shortage of professional manpower for mental health services. Public acceptance of mental health services has grown to the point where a larger proportion of the population is now seeking help. The Manhattan Study (1962) indicates that an even greater proportion of the population is in need of help. The shortage of professional mental health personnel becomes critical when considered in terms of the rapid rate of population growth. Indeed, even the current manpower shortage has resulted in gross deficiencies in mental health services.

George Albee, in his 1959 study of *Mental Health Manpower Trends*, relates the shortage in mental health manpower to the shortages in professional manpower in general. He contends that our system of secondary and higher education fails to stimulate sufficient numbers of bright, young people to seek professional careers. He attributes this to anti-intellectual, anti-educational, and anti-professional, social and cultural values. Our society rewards private initiative and individual enterprise. The maker and seller of goods reaps greater financial rewards than one who offers a professional service. Not only are the rewards greater for the entrepreneur, but his investment of time in education is considerably less, and he reaches high level earnings much sooner.

When one considers that it takes twelve years of training post-high school to become a psychiatrist, ten or more years to become a psychologist, and seven years to become a social worker, it is understandable that so few are sufficiently motivated to enter these mental health professions. Furthermore, in view of the increasing competition between private and public organizations for the already-short supply of mental health personnel, it seems that there will never be enough manpower for public service.

The state hospital, the "step-child" of the mental health field, cannot help but be affected by the scarcity of professional personnel. Low salaries and poor public image hardly help the state hospitals to compete for professional personnel. So long as custodialism was the prevailing ethos in the mental hospital, the need for professional personnel could be minimized. Traditionally, in state hospitals, professional personnel fulfilled "gatekeeper" functions, such as admissions, transfers, and discharges, while the non-professionals, the attendants, carried out the bulk of the custodial functions. Following World War II, with the advent of the somatic, chemical, and psychological therapies, and recognition of the

more favorable prognosis of the mentally ill, a demand was created for more humanistic and therapeutic regimens for patients. The state hospital, in the face of an already-short supply of professional personnel, was ill prepared to share this new Zeitgeist or more humanistic, rehabilitative services.

In an effort to meet the public clamor for more humanistic treatment, the state hospital attempted to mobilize the therapeutic potential of its least costly and most available employee—the attendant. The attendant, however, is already so heavily burdened with custodial functions that he has limited time available for therapeutic services. Furthermore, the rewards for psychiatric aide work are usually so poor that those choosing this type of employment have been reported to be only marginally employable and poorly educated. This type of background limits the degree to which these people can assimilate and apply specialized training. Although considerable effort is being invested in upgrading the training of the attendant to effect a greater therapeutic impact on the patient, this calibre personnel offers limited hope of adequately fulfilling the therapeutic needs of the state mental hospital.

Quite obviously, if the large institutionalized patient population is to be adequately treated, manpower must be drawn from sources other than existing hospital personnel. These new personnel should *not* be expected to function in the established, highly-specialized roles of existing mental health professions, but rather in new roles which will maximize the therapeutic potential of the hospital. These roles, then, must encompass a treatment function, and must be designed to serve the large numbers of patients currently untreated and languishing in hospital wards.

SOCIO-ENVIRONMENTAL THERAPY

A treatment approach which has been found to be both promising and appropriate for the large state hospital population is socio-environmental therapy. Unlike traditional hospital care, which tends to stabilize patients in custodial routines, socio-environmental therapy is designed to activate social behavior through democratic, humanistic treatment and interpersonal activities.

The Psychology Department of the Philadelphia State Hospital, during the past seven years, has been concerned with the development of socio-environmental programs for *chronic* patients, and the evaluation of the therapeutic effectiveness of different forms of this treatment. In view of the characteristic isolation and withdrawal of chronic psychotics, resocialization was considered the major objective. The social treatment programs designed to induce, augment, and manipulate appropriate social behavior included three major components; namely, a social milieu, rehabilitation skills and content, and a corrective experience.

The social milieu, or Therapeutic Community, was established by: modifying the physical environment of the state hospital to approximate that of the extramural community; changing staff attitudes to attain a more optimistic view of the chronic patients' potential for recovery; encouraging free communication among patients and between patients and staff; introducing patient social organizations to permit the emergence of spontaneous social behavior; and establishing patient government to permit patients to be more instrumental in determining and managing their daily lives.

Rehabilitation skills and content are provided in a structured group activity program consisting of group tasks varying from simple, recreational

pursuits to complex, co[illegible]ity-centered activities. Training in the repertoire of social behaviors necessary for everyday living is available in a special set of group activities. Through discussions, practice, and trips to the community, patients are instructed in personal grooming, preparation of meals, repair of clothing, budgeting, use of transportation and communication facilities, and other community resources. In addition, these activities also provide training in the basic requirements of interpersonal relations, such as the essentials of etiquette, how to meet and interact with people in new situations, and ways to deal with interperconal stress.

A corrective experience is provided throughout the program in individual counselling sessions, in group activities, and in daily life experiences. The emphasis is on providing pressure towards increased interaction, reinforcing socially adaptive behavior, discouraging and modifying maladaptive behavior, and helping patients to develop more appropriate ways of coming to grips with the problems of everyday living. To accomplish these goals, techniques which focus on the behavior of the individual and/or the group process are utilized.

Evaluation of the therapeutic efficacy of these programs indicates that socio-environmental treatment does, indeed, improve the social functioning of most chronic patients, and is particularly effective with older, more chronic patients; older patients show more favorable psychiatric adjustment and are more frequently released on completion of treatment than are younger patients.

GRADUATES OF COMMUNITY COLLEGES IN PSYCHOLOGICAL SERVICE ROLES

IN SOCIO-ENVIRONMENTAL TREATMENT—Can the graduate of community college be trained to utilize the techniques of social interaction therapy within socio-environmental treatment programs? I think they can. The Psychology Department at the Philadelphia State Hospital is currently training graduates of four-year colleges to develop, implement, and conduct such socio-environmental treatment programs on hospital wards. Graduates of community colleges could be utilized in the conduct of the various social, recreational, and industrial activities which comprise a major portion of these socio-environmental programs. In a relatively short period of time, such graduates should be able to gain an orientation to mental hospitals, develop humanistic attitudes towards mental illness, learn the specific activity skills which serve as vehicles for social interaction, and become familiar with the educational content which they would have to provide to the hospitalized patient to prepare him for return to the extramural community. Under the supervision of professionally trained psychologists, such social interaction activities could be coordinated into wide-range, socio-environmental treatment programs. With appropriate modification of program content, similar programs would become suitable for different hospital populations, i.e., emotionally disturbed or mentally retarded children and adolescents, organically impaired geriatric adults.

IN OTHER THERAPEUTIC ROLES—Mental patients confined to hospitals for the first time experience further disorientation in this new and strange environment. The interruption of the usual day-to-day processes and the further isolation which ensues from hospitalization can lead to an exacerbation of symptoms. Such additional stresses could be reduced by the assignment of an informed hospital staff member to serve in the role of "buddy" for these new patients. The "buddy," in addition to serving as a source of continuing interested human contacts, could also: a) provide new patients with an orientation to the

institution; b) serve as liaison agent between the patient and the professional staff; c) encourage and assist the patient to take advantage of existing hospital and community facilities and resources, and insure that the patient follow prescribed treatment regimens; and d) follow the patient's progress in the hospital and in after-care service. The role of "buddy" fills an existing void in therapeutic services within hospitals. Graduates of community colleges could be trained to serve in this role and thereby provide a much-needed therapeutic service.

IN PSYCHODIAGNOSTIC FUNCTIONS—Certain aspects of the psychodiagnostic functions usually fulfilled by professional psychologists could be delegated to these new personnel. Where psychodiagnostic is conducted through group administration of batteries of pencil and paper psychological tests, the administration of such tests could be assigned to these new workers. Scoring of such tests with established keys is another task which these new personnel could fulfill. Interpretation of test results, as well as reporting of findings, would still remain the responsibility of professional psychologists.

IN RESEARCH FUNCTIONS—Research, another major function fulfilled by psychologists, could well be facilitated through the assistance of new personnel. These new personnel could readily be trained to keep records, collect data, and perform simple data analysis. Research instruments are usually developed for the specific problem under investigation. Training in the application of these instruments and in the collection of the data which derives from these instruments, in most instances, can be given at the institution in a short period of time. Similarly, quantification of such data, the calculation of simple, descriptive statistics, and the evaluation of the significance of difference scores, are all techniques which the new worker should be able to learn while on the job. Such research assistance would greatly help the professional researcher in the fulfillment of his research endeavor.

SPECIAL REQUIREMENTS

In brief, graduates of community colleges could well assist in some of the innovative as well as the more traditional functions of professional psychologists in the areas of psychodiagnosis, treatment, and research. Undoubtedly, not all graduates of community colleges would be suitable for such service. Intellectual, personality, and motivational differences would make some graduates more suitable than others. The current stereotype regarding the attributes of a successful member of the "helping professions" would also apply in the selection of subprofessional workers for the mental health field: the attributes of warmth, sensitivity, emotional expressiveness, independence, flexibility, and interpersonal skill are undoubtedly to be sought in the selection process. In addition, these new personnel would be expected to know something about human behavior (both normal and abnormal), personality development, social institutions (i.e., the family, the school, the hospital), and the roles and functions of the various mental health professions. It would also be of considerable utility to the new worker to gain knowledge of group dynamics and some skill in working with groups of people. Those graduates who meet the basic requirements in knowledge, skill, and personality will undoubtedly be able to make a contribution to mental health service and find plentiful career opportunities for themselves in this field.

CHAPTER 12

MIDDLE-LEVEL MENTAL HEALTH MANPOWER AND JOB FUNCTIONS RELATED TO SOCIAL WORK

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The shortage of professional social workers in psychiatric settings is acute and there is considerable evidence that the growth of preventive and treatment programs is far in excess of the training capacities of our nation's graduate schools of social work. A recent study of social work personnel in Georgia, conducted by the State Board of Regents, found that 86 percent of the state's employed social workers did not have professional training.

Many of the persons doing jobs related to social work are in mental health settings, in primary treatment agencies, or in facilities dealing with prevention or aftercare.

There are gaps in services to the mentally ill and mentally retarded which can be bridged by middle-level personnel who are less than professional but have skills which are at a higher level than that which is usually expected of an attendant or aide. The following activities can be accomplished, in whole or in part, by middle-level mental health workers, under the direction of professional social work supervisors:

1. Interview patients and families for factual historical information. (Few hospitals for the mentally ill and/or retarded can afford the time of professional social workers for this task with all patients and families.)
2. Obtain background information from community agencies.
3. Prepare written abstracts and reports for other agencies.
4. Conduct focused interviews with patients and families in relation to specific, goal-oriented, reality situations.
5. Lead reality-oriented group orientation sessions with patients. (Orient patients to milieu.)
6. Assist patients with community adjustments following release, through assisting them in obtaining help from various community agencies.
7. Conduct residence studies; correspond with officials of other states; implement interstate transfers when relevant and appropriate.
8. Assist released patients in vocational preparation and job-finding.
9. Assist in routine follow-up of former patients who reside in nursing homes, halfway houses, group foster care, and other community-based semi-institutions.
10. Develop and coordinate leisure-time activities in social-recreational facilities which provide much-needed breadth to the lives of former patients.

An additional task defies categorization as simply as the above activities, but is of great importance. It is the job of relating to and helping those families who reside in almost every community, and who have multiple problems, contributing disproportionately to the populations of mental hospitals and costing society a vast amount because of their economic dependency, lack of productivity, poor health and nutrition, and numerous related problems in social functioning. Typical helping techniques are not usually effective because the recipients of services are not motivated to improve their lots; they have not experienced enough success to realize that mobilization and striving can be followed by gratification. A middle-level worker may be able to help such families by working only with one or two at a time, demonstrating home-making skills, sanitation, etc., or preparing them for Head Start or other community programs that they have not been able to utilize. This kind of work would require a long-term, almost live-in type of relationship, but it is the kind of service that future agencies will be providing for "hard-to-reach" multi-problem families.

The above list is suggestive and illustrative rather than exhaustive. It will be noted that the tasks are somewhat comparable to those typically done by social work aides, or public health nurses, or rehabilitation counselors. With adequate selection and training of middle-level personnel, followed by qualified supervision, there is every reason to believe that they can accomplish several important jobs with thousands of patients who are now without these services.

Personnel at this level will need to demonstrate abilities to establish facilitating relationships, communication skills, freedom from authoritative and judgmental tendencies, and acceptance of people in trouble. They should be provided with learning experiences to prepare them for beginning work under supervision, and those who perform well in their jobs should be guided into completion of undergraduate and professional training if they are motivated for continued study.

CHAPTER 13

THE MENTAL HEALTH WORKER IN NURSING SERVICES

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It is proposed that an appropriate assignment for a mental health worker may be found in the nursing department of a hospital, clinic, or mental health center. Supervision and direction should be provided by a graduate nurse, a clinical specialist in psychiatric nursing. Such supervision is mandatory in order that the duties and functions herein described be assumed and skills developed.

It is trite to state that hospitals are changing. The goals, although they may not be in writing, have changed. The organization has changed. Programs of treatment have changed. The mental health worker's educational program should prepare him to function in different settings, with different types of patients, in today's changing mental health facilities.

For clarity, three possible types of assignment are mentioned. However, differing organization patterns from hospital to hospital may not make possible each of these assignments, such as to an admission, chronic, or geriatric service. If the "unit" system is the basis of organization, the acute or chronic services tend to be eliminated or blurred to some degree. The functions and skills needed to work in these assignments are not mutually exclusive.

First of all, a large group of long-term, chronic, or backward patients may be found in a hospital. These patients may or may not be housed on locked wards. No matter what the circumstance, the care provided often continues to be custodial in nature and mutual withdrawal of patients and staff predominates the environment. Those patients who reside on open wards may still spend their day in isolation and are characteristically withdrawn from professional and non-professional staff. Interaction with others is at a minimum. Little consistent treatment effort is made to interfere with socially unacceptable or disruptive behavior and protection is based on restriction rather than the promotion of healthy behavior patterns. A major role of a mental health worker in such a unit (ward) would be dependent on skills providing educative experiences which reinforce socially acceptable behavior and which emphasize a socio-therapeutic approach to care.

On the other hand, today's psychiatric treatment tends to keep the patient in the community by alternatives to hospitalization, or to return him to the community as soon as it seems possible. Admission rates of the hospital are increasing and the time periods of hospitalization are decreasing. The rapid turnover of patients has made it necessary to re-tool treatment plans from those of long-term hospitalization to long-term treatment, or availability of treatment wherever the patient may be. The treatment goal for patients in the hospital

is to modify behavior so that he may be returned to the community in a matter of days or weeks, rather than months or years.

These patients receive a different orientation to the hospital from that which the long-term patient has had. He is immediately confronted with a treatment regimen which communicates the expectation that he will leave the hospital in a short period of time. Modification of behavior unacceptable to society is expected. Nursing care is planned for short hospitalization.

Thirdly, the hospital may have a community health program which includes home treatment or after-care. When a treatment program has been established, the patient leaves the hospital for his home, a foster home, or nursing home. He returns to the hospital for follow-up or receives visits in the home from an appropriate hospital worker, the physician, the social worker, or the nurse. As the patient's adjustment to the community is established and a determination made by the psychiatrist, the mental health worker may, under the close supervision of the nurse, provide supportive services to selected patients through home visits. These services, a part of the after-care program, aid in the maintenance of health services and the provision of continuity of care.

Using the above as a guide to possible assignments, the mental health worker should have beginning skills which include the following:

1. *The ability to instruct the patient in activities of daily living and to utilize these activities to facilitate interaction.*

   Grooming, including as necessary: toilet training; cleanliness of body; proper care of hair and nails; appropriateness and neatness of dress and makeup, etc. (Take to bathroom on regular basis until patient goes by himself; show patient how to take a bath rather than bathing him; teach him how to comb his hair; conduct classes in grooming; teach him how to wash and iron clothing; teach table manners and proper eating habits.)

2. *To accept patient's behavior.*

   Be tolerant of patient behavior, yet able to set firm limits.

3. *To provide for safety and comfort of patients.*

   Teach patients how to make their beds; to keep their room or area about the bed clean; teach how to clean bedside stand; teach how to ventilate rooms properly.

   Protect patient and others from "uncontrolled" behavior.

   Encourage appropriate health habits, i.e., sleeping, eating, etc.

4. *To utilize self as a therapeutic tool.*

   Orient patient to hospital, the treatment program and hospital's expectations of patient; allow patient to communicate his expectations and needs.

   Increase communication with and among patients. (Listen to and talk with patients; respond in appropriate manner so as not to reinforce delusional content; or respond in manner which keeps communication lines open or limits inappropriate or bizarre talk; maintain patient's identity.)

5. *To organize work.*

   Plan assignment to make best use of time. Schedule activities with and for patients.

6. *To utilize group skills.*
   Conduct such patient groups as patient government or "group living" units.
   Simple diversional activities: first providing for patients and, as patients are able, assist in organizing recreational activities.
   Provide simple occupational skills, i.e., teach how to cook and serve meals; how to sew and mend own clothes.
   Encourage interest in hobby or hobbies.
7. *To introduce patient to or encourage contact with community and community activities.*
   Orient patient to community by attending activities in the community; developing or redeveloping patient's interests in community resources (escort to church, museums, etc.).
   Teach, if necessary, how to use public transportation and shop in stores.
8. *To observe.*
   Recognize changes in patient behavior such as signs and symptoms of increased anxiety, tension or impending panic, increased depression or activity.
9. *To communicate with and report to other members of hospital staff.*
   Participate in nursing care and treatment conferences, report changes in patient's condition, keep notes, and write reports.

The ideas and opinions expressed in this paper are those of the author and do not necessarily reflect those of the Department of Health, Education, and Welfare, Saint Elizabeth's Hospital.

CHAPTER 14

NEEDS OF VOCATIONAL REHABILITATION CLIENTS WHICH COULD BE MET BY MIDDLE-LEVEL MENTAL HEALTH WORKERS

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The role of the vocational rehabilitation counselor is changing rapidly. Counselors are now being expected to perform many duties which have not previously been considered part of their function. In many offices, counselors now have a team of psychologists, social workers, instructors, evaluators, and other rehabilitation therapists working under their supervision. In such settings, the counselor becomes an administrator, planner, resources mobilizer, and coordinator. As a result of these added duties, many counselors find that they have far less time to spend with each client than they need. Many day-by-day needs of clients are not being met as effectively as necessary to assure their rehabilitation.

In addition, Vocational Rehabilitation has shown a phenomenal growth in the number of clients being served. Yet, the number of additional counselors has not kept pace. It is estimated that 1,000 new counselors will be needed yearly for the next several years to close the service gap.

As it will not be possible to secure as many professionally trained counselors as needed, additional action will need to be taken to assure that clients receive essential services. What is the solution? Dr. C. H. Patterson proposes to use "subprofessional workers" or "counselor assistants." According to Dr. Patterson:

> . . . Many of the things counselors are now doing do not require persons who are trained at the professional level of counseling.
>
> Many of the things which counselors are now doing could be done by persons with less than the two years of preparation necessary for professional counseling.[1]

Dr. Patterson's proposal seems to be fundamentally sound. In fact, I believe that many of the functions could be performed by persons with a secondary school education plus a special training program at the junior college or community college level. Although such workers could be used with the physically disabled, they are particularly needed to help rehabilitate the mentally ill and retarded. Such a worker, of course, would not attempt to function autonomously, but would function as a part of the rehabilitation team. Each worker would be expected to maintain a relationship with a specific group of clients and would be supervised by a professionally trained counselor.

It seems to me that eight major needs of mentally ill clients could be met more effectively if middle-level mental health workers were available.

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[1] C. H. Patterson, "The Rehabilitation Counselor: A Projection," *Journal of Rehabilitation*, January-February, 1956, p. 31.

PROGRAM ORIENTATION AND CLARIFICATION

As a psychiatric patient enters into a rehabilitation program, the impression he forms during the first week or two often determines the extent of his active participation. Entry into a complex rehabilitation program is an overwhelming experience for many clients. The client is "grilled" and "inspected" and "tested" by a counselor, psychologist, and numerous other high level professional people. Being in a strange place with new rules and regulations, he is expected to remember many new names and to keep all the instructions and time schedules straight. He is often reluctant to ask for clarification. If the client is confused and overwhelmed—if the procedure doesn't make sense to him—he is apt to withdraw or, at best, participate on a limited basis.

There is need for a less awesome staff member to serve as a guide and "friend-at-court" as the client moves through this initial stage of the process. Many questions about forms, tests, appointments, etc., need be answered by someone who knows procedures thoroughly, but the counselor is not always available. The worker could help orient the client and be available to clarify procedures. In addition, he could help prepare the client for interviews and examinations by encouraging him to answer questions candidly. Many clients need such encouragement before they will reveal their inner thoughts and past behavior.

PSYCHOLOGICAL ISOLATION REDUCED

One of the most common symptoms of clients with emotional disorders is their feeling of social and psychological isolation. As a result, many find it difficult to participate effectively in the various rehabilitation therapy, evaluation, and training activities.

It would be helpful to have a worker who would "sponsor" certain clients who need emotional support. This would entail developing a close, informal relationship with the client on a non-therapist basis.

He could encourage the client to attempt new experiences and help him form constructive relationships with other clients and staff members. He could encourage clients to become involved in various social group experiences recommended by the treatment team. Working behind the scenes, he could help the client gain acceptance from others. Many clients need encouragement to continue in group activities after misunderstandings or conflict have occurred.

This "personal interest" might give some clients that additional emotional strength they need to become actively involved in their own rehabilitation, to look at themselves and their situations realistically, and to resolve their problems rather than escaping from them. The worker's consistent availability to the client would be extremely important in reducing his social isolation.

TREATMENT CENTER RESOURCES MOBILIZED

Another common characteristic of mentally ill clients is that they have been unable to mobilize existing resources to help in resolving their problems. Most clients find it even more difficult to understand the roles played by each professional discipline, department office, or worker within a treatment center.

Most clients do not know what each portion of the program has to offer or how to enter various activities. In a complex treatment center, it is not easy for a patient to "know the ropes." Many do not know where to go or to which

counselor, social worker, or psychologist to talk about a particular problem, e.g., getting a pass to visit home, arranging for work clothes, getting their eyes examined, getting on the patient payroll, exploring a possible job opportunity, or getting into group therapy.

If a worker who was well acquainted with the structure of the hospital and roles of staff members were assigned to maintain a close relationship with a small number of clients, he could help them mobilize the hospital's resources more effectively. He could help clients understand procedures, specific persons to see, when it is best to see them, where they are located, and the reasons for certain steps, delays, etc.

OCCUPATIONAL EXPLORATION AND TRAINING

The occupational goal and level of competency of many clients is difficult to determine. This is particularly true of young people with little education or work experience and of anyone who has spent much time in an institution. To guide clients effectively, it is important that a counselor determine each client's occupational and social assets, interests, and deficiencies. To help define these, many clients need to be observed in a series of actual work experiences.

As was found in the South Carolina State Hospital, more than a hundred work exploration opportunities exist within each treatment center, e.g., maintenance departments, housekeeping, food services, and various offices. In addition, several special evaluation and training facilities have been established, e.g., the trades' training shops, home economics, cosmetology, and commercial instructions programs. In such settings, a counselor can determine the feasibility of entering a client in an instructional or training program after his release from the hospital.

A counselor plans the work evaluation program with each client as part of his total treatment program. From that point on, a Work Assignment Officer or Industrial Therapist makes the actual placement and follows the client's progress. He obtains regular reports from work supervisors, writes progress reports, and provides feedback information to the counselor and treatment team. He handles many day-by-day problems of clients and serves as liaison man between the counselor, client, and work supervisors.

A dozen such workers have been used successfully for five years in South Carolina. They are all former aides with a high school education plus experience in a mental health setting.

SOCIAL SKILLS DEVELOPED

Far more workers are dismissed for deficiencies in social skills than for occupational skill deficiencies. Mentally ill and retarded clients generally need help in developing social skills as part of their total rehabilitation program. Many need help in learning how to relate more effectively to others, to trust others, to help others constructively, to receive suggestions or assistance, and to develop friendships among their co-workers and neighbors. Others have lived such a treadmill existence, they need to learn all over again how to play, to relax, and enjoy themselves.

Although counselors and other treatment team members prescribe activities in which clients may develop improved social skills, they seldom have time to participate with the patients in these activities.

It would be most helpful if junior-level staff members were available in treatment centers to establish close relationships with selected patients and help them improve their interpersonal relationships. Serving as models, they could participate with small groups of patients in planning and carrying out special projects, recreational events, parties, picnics, dances, ward meetings, and informal discussions of grooming, marketing, applying for employment, etc. Patients would thus gain experience in working with others toward common goals. Being sensitive to the needs of socially isolated patients, workers could slowly involve them in various social group experiences, helping them feel more comfortable and gain satisfactions from their relationships. To perform this function effectively, workers would need to be quite mobile within the hospital setting.

SELF-CONFIDENCE AND MOTIVATION

What is it like to be a mental patient? Most all have had problems so severe that they have become immobilized. Some have had their emotional energy slowly sapped by years of frustrations, disappointments, and conflict. So many ideas and plans that seemed appropriate have failed. Some carry deep-seated guilt regarding past behavior. Many have burned bridges to a normal life and have used up their financial resources. The very people who mean the most to the patient—his family and friends—are all too frequently unable to provide the emotional acceptance and support he needs. The path behind seems like a nightmare and the path ahead is just an evasive dream.

The task of motivating such people is not an easy one, yet it must be accomplished. Clients need help to develop their assets and skills, recognize their accomplishments, establish realistic goals, and find paths to reach these goals. Self-confidence is built upon layer after layer of achievement.

Throughout the entire process, clients need understanding, acceptance, and encouragement. Consistent encouragement may mean the difference between success and failure.

Constant emotional support from a mental health worker, as the client plans, makes decisions, and attempts to improve his mode of functioning is often more important than the level of instruction or guidance provided. A middle-level worker should be able to give this support quite effectively. He could help the client build on his strengths rather than dwell on his weaknesses.

FAMILY AND COMMUNITY SUPPORT

As a client leaves a treatment center and attempts to reestablish himself in the community, he needs to receive a warm welcome from his family and friends. Yet, these people are often quite anxious or fearful and don't know exactly how to act toward him. Their actions range from rejection, hostility, and humiliation to over-protection and "smothering." If the client has been away for some time, family members have at least partially restructured their lives to exclude him.

Many of these families would profit from intensive family counseling, but there are not sufficient counselors or social workers available to help them understand and aid the client's adjustment.

If a middle-level worker were available, he could visit with relatives and other interested parties several times before the client's return and during the first few weeks after it. He could acquaint them with the client's hospital activity

program, keep them posted on his progress, pass on suggestions made by the treatment team, and discuss possible plans and alternatives for the future. If a relationship were maintained with the client's family, they would be better prepared to receive him in a constructive manner. Such counseling could be supervised by an experienced counselor or social worker.

COMMUNITY RESOURCES MOBILIZED

As stated previously, many clients need help in mobilizing resources in their community. Many have misconceptions regarding the function and structure of various agencies. Others have simply not known that medical, legal, financial, educational, or counseling assistance was available—or did not know how to gain it. With such rapid changes being made in many governmental programs, the lay person finds it difficult to know where to go and whom to see to gain help. A middle-level worker could help clients become aware of resources and procedures.

In addition, such a worker could serve as assistant to the local counselor in maintaining contact with clients who are in training or employment phases of rehabilitation. He could actually make many of the arrangements for placement of clients in training centers. He could help the client arrange for such things as transportation, tools, uniforms, living quarters, moving, recreational activities, etc. He could make regular follow-up contacts with the client to help him solve the many problems which confront him daily—and which jeopardize his rehabilitation if left unresolved.

Counselors have found over and over again that the frequency of visits by a worker, particularly during the first several months after treatment, may make the difference between success and failure. Weekly or semi-weekly contacts with a client may sustain him, but the situation can "fall apart" if no contact is made for two or three weeks. Unfortunately, the counselor's priority must frequently be given to the long line of new clients in his office rather than to clients already on the job or in training.

As indicated in the preceding pages, I feel that the mentally ill and retarded have many needs which could be met effectively by middle-level mental health workers. The rehabilitation process would be enhanced if such workers were available.

CHAPTER 16

MENTAL HEALTH WORKERS IN REHABILITATION THERAPIES

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The field of Rehabilitation Therapies, denoted as Activities Therapies, is fertile ground for the productive and therapeutic employment of so-called "sub-professionals," "semi-professionals," "semi-skilled," or "assistants." Lest my colleagues, in "the professions" that are coordinated under this umbrella term of Rehabilitation Therapies, get the impression that we do not need professional people, let me set the record straight right now—we do, but we are not producing these trained people in quantities adequate to the need. It, therefore, behooves those of us in the field to look to other possible sources of manpower to perform those rehabilitative tasks that need so desperately to be done in our mental hospitals and can be done by persons with less formal training. That this kind of person can contribute enormously to a rehabilitation program is attested by the fact that we in Maryland, and our fellow coordinators in state mental hospitals across the nation, have had to develop our rehabilitation therapies programs with a small nucleus of trained professionals and a predominant number of interested, enthusiastic, and capable persons whose personality traits and innate potentials have helped attain the professional recognition as a medical discipline that we enjoy today.

For the purpose of this paper I am confining my remarks to four major categories:

1. What are Rehabilitation Therapies?
2. What are patients' needs?
3. Which needs are not being met and how can these be met by a "mental health worker?"
4. What should go into the training of such a person?

The primary and ultimate goal of Rehabilitation Therapies is that of re-socialization and/or "re-education for living." By making available through the media of occupational, recreational, industrial, musical and educational therapies, opportunities for the patient to "learn to live better with himself and others," and to aspire to his maximum social and vocational potential, we help him to achieve this goal. The kinds and types of programs we offer are varied and diversified depending upon the individual's and/or group's needs. We attempt to help strengthen the patient's self-image and interpersonal relationships through a continuum of the three R's—examination, education, and rehabilitation. This, of course, makes necessary constant re-evaluation of our services in light of the patients' needs.

What are the patients' needs? Basically and broadly, they are the universal emotional needs of all people, i.e., the need for conscious self awareness; the need to be cared for, and more essential, to be cared about; the need to belong and to be socially acceptable; the need to make a positive contribution to society, be it family, work, friends, etc., within or without the hospital; the need for self-assurance and recognition; and the need for satisfying refreshment or relaxation. In addition there are, of course, the basic physical needs of food, clothing, shelter, and medical attention. Since other disciplines are primarily responsible for this latter group of needs our concern is, therefore, more directed to the emotional, social, and vocational needs.

More specifically, patients need to communicate their wishes, hopes, fears, frustrations, likes, dislikes, etc. Communication is a two-way process, be it verbal or non-verbal. There must be a sender and a receiver. This is an almost impossible situation when you are one of sixty to eighty patients on a ward with one nurse, perhaps an hour of planned rehabilitation activity daily, the possibility of seeing a doctor or, sometimes, a social worker if you're lucky or really in need. To whom do you communicate then? Other sick people? Perhaps, but most often you stop communicating and succumb to "hospitalitis"—a conformity to the *status quo*. Mental health workers can be the missing link in this kind of situation.

They can motivate and stimulate the patient by using various media—art, music, games, dances, writing—and being good listeners and effective liaison with the professional staff.

Patients need personal attention so as to improve their personal appearance, hygiene, manners, and habits, thus making them more socially acceptable. Continuous daily on-the-ward programs of grooming, cleanliness, and the care and repair of clothing, could well be done by mental health workers. The formation of undesirable habits could be eliminated by early detection, and the reinforcement of those that are socially acceptable could be implemented.

Patients need people to do things with and for as well as people to do things with and for them. They need the opportunity to strengthen all their positive behavior so as to submerge and/or eliminate the negative responses. They, therefore, need a "manager"—one who sees to it that a patient's plan for rehabilitation is a continuous and on-going process and that the patient does not get "lost in the shuffle." Mental health workers could be most effectively used in this capacity, and thus eliminate the patient's getting lost between disciplines.

Patients need to become self-sufficient. Mental health workers could assist in skill development projects and as work evaluators. They could also be used in programs of self-management and education.

Patients, as to most people in our society of the decreasing work week, need to develop wholesome use of their leisure time and to be able to become part of the outside community functions. Mental health workers could well be used in this supportive role.

I hope that, in presenting these ideas, I do not give the impression that none of these things is being done in our rehabilitation therapies programs. They are, but there are so many needs, and so many patients not being reached adequately. Some patients (intensive treatment units) are engaged in several

programs while others receive very meager services or none at all. Following are the average daily percentages of patients reached in our present programs:

Music Therapy	12%	Recreational Therapy	60%
Art Therapy	2%	Education (Adolescents)	25%
Occupational Therapy	16%	Education (Adults)	3½%
Industrial Therapy	36%		

These percentages may vary slightly from one hospital to another; however, one can easily see there is still a huge job to be done.

Having established the need for "mental health workers," what kind of educational preparation and screening is essential? In my experience, I find that personality traits and attitudes are more important than skills and techniques. Therefore, in screening potential candidates for training, it is recommended that one consider the following: One who enjoys working with people rather than things, one whose frustration tolerance is high, one whose perseverance is great, one who enjoys being creative, and one who is emotionally stable. Academically, it is recommended that consideration be given specifically to courses in self-expression (verbal and written), psychology (normal and abnormal), group dynamics, and sociology. If there is an opportunity for electives, techniques in art, music, drama, teaching, and recreation could be helpful. It is understood that the hospital which employs such a person would provide professional and on-going, in-service training and supervision.

In conclusion, and to summarize, "people need people" and "patients are people." And, like the Drs. Menninger, I feel that if we invest more in personal services to our patients we will not need so many bricks.

CHAPTER 16

THE PROPOSED ACTIVITIES OF A COMMUNITY MENTAL HEALTH WORKER

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The following activities are taken from the responses of Mental Health Workers in Florida and of VISTA volunteers in West Virginia with a few suggestions made by others. They represent the kinds of community mental health duties actually being performed by people who presently think of themselves as community mental health workers. These people now have training that extends from a high school diploma only to a master's degree in various specialties.

Some of these duties would require specific training in certain techniques either during their schooling or in in-service training periods early in their employment. However, they all would seem to be activities that could be carried out by a person with a community or junior college background that gave some special attention to mental health and to understanding of the community and how it works.

A. *Work with individual patients or disturbed persons and their families*

1. Does individual counseling
2. Does group counseling
3. Carries out pre- and post-hospital care visits
4. Sees suicide referrals and works with suicide prevention service
5. Interprets laws, hospital policies and practices to patients and families
6. Makes home visits to families during hospitalization, to patients and families after hospitalization
7. Leads returned mental patients' group
8. Does psychological testing of screening sort
9. Does emergency consultations
10. Does counseling—epileptics, alcoholics, Cuban refugees, parents of retarded, school students
11. Assists patients in making financial or other arrangements for transportation to clinics, for living needs, for medication, etc.
12. Attends meetings of social rehabilitation club for ex-patients.
13. Visits ex-patients or disturbed people in nursing homes
14. Works with AA groups
15. Works with jail prisoners who are disturbed
16. Operates or works in nursing home, personal care home for ex-patients, etc.
17. Assists patients to find living accommodations, homemaker services, etc.
18. Assists patients with legal restoration procedures
19. Works with patients in various capacities in day hospitals

B. *Work with or for other agencies to facilitate the management of individual cases*

1. Makes case investigations for county judge
2. Serves as liaison with physicians, county health officers regarding admissions and releases
3. Works with public health nurses and visiting nurse associations—especially in aftercare
4. Does home investigations for hospital staff
5. Serves as liaison with ministers, welfare officers, employers, vocational counselors regarding restoration of patients
6. Works with school staffs—teachers, principals, guidance counselors—regarding problem children
7. Serves as liaison between clinic and outlying counties, other agencies, etc.
8. Assists in referrals to occupation center and vocational rehabilitation in general
9. Initiates petitions for incompetency hearings
10. Does investigations to determine residence; also does follow-up reports and home studies for other states
11. Reports on ex-patients to hospitals at 11 months (before trial visit status expires)
12. Does home investigations, special studies, and referrals for juvenile court
13. Checks on broken appointments
14. Attends case conferences of other agencies working on behalf of patients
15. Accompanies or advises sheriff or police on calls regarding disturbed people
16. Does psychometrics exams of screening kind for schools, Vocational Rehabilitation, Crippled Children's Agency, etc.

C. *Consultation to agencies regarding mental health problems in general*

1. To juvenile courts, courts in general, police and sheriffs
2. To schools—principals, guidance counselors
3. To health departments
4. To mental health planning groups, including mental health associations
5. To VRA
6. To welfare, child welfare agencies
7. To associations for retarded children
8. To other state and local agencies

D. *Teaching*

1. School students regarding: alcohol, sex education, VD, mental health careers
2. Jail personnel
3. General public regarding mental health, mental retardation, mental illness, treatment and resources; talks, films, workshops

E. *Community action*

1. Serves on boards of mental health associations
2. Promotes development of ex-patient clubs
3. Promotes and mobilizes comprehensive mental health programs (i.e. sheltered workshops, halfway houses, nursing homes)
4. Interprets community needs to state agencies
5. Assists in mental health surveys and assessments of need

6. Helps communities organize preventive programs
7. Serves on committees or boards in rehabilitation, retarded children, juvenile delinquency
8. Be a resource person

F. *Administration*

1. Keeps data on local problems
2. Collects data—forms and reports
3. Provides administration of emergency service (call roster, etc.)
4. Orders, distributes, and reports of medication for trial visit patients
5. Maintains contact record and file (including case registers)

G. *Research*

1. Does studies of special problems
2. Does analysis and evaluation of own program

APPENDIX

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